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MEDICAID PROGRAM EVALUATION: FINAL REPORT

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Opinions expressed do not necessarily reflect the views of the U.S. Department of Health and Human Services, Health Care Financing Administration, which sponsored the project.

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PREFACE

The Medicaid program, which finances health care for over 20 million Americans, has been the focus of increasing attention in the 1980s as concerns about cost, access, and quality have mounted. Various proposals--from sweeping reallocations of responsibility to very fine adjustments of regulations--have been brought forward by the many parties interested in the program, and some important changes have become law. The Medicaid Program Evaluation has selected the most salient changes in the program, to see how they have been implemented in the States and to assess what effects they have had for the financing and delivery of care.

This evaluation focuses on specific changes in the Medicaid program rather than trying to assess from the ground up how the program is performing. The discrete task of the evaluators is to take policies put in place in the early 1980s and weigh their consequences: given what the policymakers intended, what happened? The practical goal is to make the experience of the first half of the decade available to inform the next round of policy changes: what are the levers of control for Medicaid?

The changes of the early 80s did not include the total realignment of responsibilities of the "New Federalism" or similar proposals. Some of these plans would have made Medicaid entirely a Federal responsibility (in trade for giving AFDC to the States); others would have given acute care to one level of government and long-term care to the other. Rather, Medicaid retains at this writing its fundamental structure as a joint State-Federal program, administered by the States within a Federal framework and jointly funded. The changes of the 80s, beginning with the Omnibus Budget Reconciliation Act (OBRA) of 1981, nevertheless broke new ground in important ways: State long-term care

programs were able to fund community care, even non-medical services, with the dual goals of serving people better and more economically; hospitals could be paid in new ways to encourage efficiency and lower cost; free choice of provider could be modified to provide for case management, HMO participation, or selective contracting; and for the first time a substantial, though temporary, reduction in the Federal matching rate was instituted. In many ways these changes and others enacted at the same time are the most substantial reforms attempted in the history of the program. How they worked and what directions they give for the future of Medicaid is the subject of this evaluation.

Medicaid Policy, Policymakers, and Evaluation

Medicaid is different from most programs managed by the Federal government in that it is only partly Federally controlled; in a very real sense, Medicaid is 50 State programs, plus a few for the Territories. The common framework is elaborate, such as regulations governing matching rates, minimum services, or conditions of participation, but each State has made different choices and evolved different policies within that structure. Policy legislated in Washington is more or less a signal to the States rather than a directive, to be received and interpreted according to both long-term orientations and immediate situations that determine State behavior in response. Many times States make responses that are unanticipated; the term "gaming" is often applied to innovative State actions, for States are entitled to maximize their own interests within the Federal framework. The link between Medicaid eligibility policy and the two great welfare programs, AFDC and SSI, further complicates the policy picture. Decisions in this area quickly involve arcane

rules and complex interactions. It is no wonder that Medicaid policy is largely intelligible only to the few who make it their daily business.

Yet despite its complexity and indirect nature, it is both necessary and possible to make policy for the Medicaid program as a whole. It is necessary because Medicaid touches the lives of millions, and accounts for over $40 billion in government spending at all levels; it is possible because it is done continually. It is the commitment of this program evaluation that better policy can be made if the levers and interactions of change are better understood, both by State and Federal policymakers.

Development of the Evaluation

In preparation for this project, HCFA commissioned an evaluation planning exercise in which a team of evaluators went to over 40 persons in policymaking positions. These policymakers included Department, OMB, and Congressional staff, representatives of interest groups, and State personnel. We asked them about the issues they saw emerging in Medicaid, and the information they most needed. The results of this portion of the study were published in 1982 as Evaluation Options for Medicaid (1), and constituted the foundations of all further work.

The second step in the evaluation process was a short-term study of those issues in the evaluation plan which could be addressed with available data. These included eligibility policy, long-term care, and dual entitlement. The results of this portion of the study have been published as Short Term Evaluation of Medicaid (2).

To continue this work, a major series of research contracts was let in 1983. Three firms, each with several subcontractors, were engaged to prepare studies on the major issues. The topic areas and questions were summarized as follows:

1. Home and Community Based Waiver Program. Under Section 2176 of OBRA 1981, States under a waiver may institute a variety of home and community based services to individuals who "but for" the waiver would be in long term care institutions. (1) Has the program reduced institutionalization? (2) Has the program reduced costs? (3) Has there been cost shifting from other programs, specifically Titles XX of the Social Security Act and III of the Older Americans Act? (4) Can we identify the elements of a successful program?

2. Financial Incentives for Family Care. Several States provide financial support through direct payments or tax incentives to family members to help them to care for their elderly relatives in the home. The major questions are: (1) What programs are in operation? (2) What have been their costs and savings? (3) Who are the beneficiaries of such programs, and what are their characteristics? (4) What are the characteristics of successful programs?

3. Inpatient Hospital Reimbursement. To help bring hospital costs under control, OBRA 1981 granted the States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Major questions are: (1) What responses have States made to the options permitted by Federal law? (2) Have reductions in expenditures resulted? (3) Specifically, what has been the impact of the California program? Two other State programs will be studied for comparison. (4) What have been the effects on recipients and providers of care? (5) Have costs been shifted to private payers? (6) To what degree and in what ways has the implementation of Medicare prospective reimbursement impacted State Medicaid programs?

4. Freedom of Choice Waivers. Under Section 2175, OBRA 1981, states may institute a variety of programs (with and without waivers) to reduce costs by limiting the provision under Medicaid which guarantees freedom of choice of provider. Major questions are: 1) How have the States responded to this provision? (2) Have there been program savings? 3) How have access to and quality of health care been affected?

5. Eligibility. OBRA 1981 contained several changes which directly and indirectly reduced the number of persons eligible for Medicaid. The major questions are: (1) How have the States responded to these provisions? (2) How have eligibility changes in related programs (AFDC and SSI) affected Medicaid enrollment? (3) How have entitlement and expenditures been affected? (4) How has the reduction in Medicaid coverage affected other assistance programs, out of pocket expenditures, and costs to hospitals and other payers?

6. Cost-Sharing. Under TEFRA 1981, States permitted to impose nominal copayments, with certain limitations, to reduce program outlays and to instill cost-consciousness on the part of the recipients. Major questions that arise are: (1) How have the States responded and (2) What has been the effect of copayments on utilization and costs?

7. Federal Financial Participation. OBRA 1981 provides for the reduction of Federal matching funding for three years, beginning October 1, 1982, subject to certain exemptions. The major questions are: (1) Which States were exempted from the reductions and for what reasons? (2) How much did the Federal Government save? (3) How did the States adjust to reducing funding?

8. Other Issues. Policy developments subsequent to the design of the evaluation were added later. These included the effects of Medicare prospective payment on Medicaid, and Medicaid coverage of children. The present report, with the detailed documents that support it, represents the culmination of this process.

Acknowledgements

We are indebted to many people throughout the country who made it possible to conduct the Medicaid Program Evaluation. Their knowledge, insight, and support greatly enhanced all phases of the project from the initial development of issues to the writing and revision of the final reports.

The project benefited greatly from the support of the members of the central and regional staff of the Health Care Financing Administration and other Federal agencies, who provided access to needed information and shared their experience on the many topics covered by the evaluation. Their incisive comments and timely assistance expedited many project activities and, more importantly, helped us to stay abreast of events in federal Medicaid policy and operation. Particular thanks due to the leadership of HCFA's Office of Research and Demonstrations, for supporting the initiation of the evaluation and seeing it through to completion.

The elaborate output of studies and reports of the Medicaid Program Evaluation is the result of the efforts of numerous organizations and individuals over several years. Three prime contracts involved nine organizations, in all: LaJolla Management Corporation with SysteMetrics

conducted studies of home and community-based care waivers and financial incentives for family care, Study Areas 1 and 2, respectively. Abt Associates with Health Economics Research and Compass Consulting conducted evaluations in Study Area 3, inpatient hospital reimbursement. James Bell Associates with The Urban Institute, Syracuse University, SysteMetrics, and the National Governors' Association evaluated changes in Medicaid eligibility, primary care case management under freedom of choice waivers, cost sharing, federal financial participation, and new legislation (Study Areas 4 through 8). They were also responsible for the synthesis and summary of findings from all eight study areas. In short, this report is very much the collaborative product of the following individuals:

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In sum, the Medicaid Program Evaluation has relied on an ongoing dialogue with our colleagues in State programs, the Assistant Secretary for Planning and Evaluation, Congressional staffs, policy centers such as the National Governor's Association, the American Public Welfare Association, or the Intergovernmental Health Policy Project, advocacy groups such as the Children's Defense Fund, and of course, HCFA. Medicaid people across the country form a professional community concerned with improving the financing of quality health care for needy Americans; it is with them in mind that the Medicaid Program Evaluation was conceived and conducted.

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EXECUTIVE SUMMARY

Passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981 initiated the most substantial reforms in the history of the Medicaid program. These included reductions in Federal financial participation (the "matching" rate); restrictions in eligibility for welfare (AFDC) benefits, to which Medicaid eligibility is tied; and greater flexibility in States' choice of Medicaid policies than the statute previously allowed. Since OBRA 1981, subsequent legislation has introduced further changes but it was not the only stimulus for change[1] in 1982, because of a severe nationwide economic recession, state revenues fell significantly short of spending commitments, providing an impetus for Medicaid spending cuts that was independent of Federal Medicaid legislation.

The Medicaid Program Evaluation is a broad analysis of the changes in the Medicaid program since 1981, involving numerous diverse studies conducted between October 1, 1983 and September 30, 1986. Major findings from this mix of quantitative and qualitative analyses are highlighted below, by chapter. A complete listing of the MPE Working Papers can be found in Appendix A. Copies may be obtained by contacting:

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1. Other recent Federal legislation affecting Medicaid includes the Tax Equity and Fiscal Responsibility Act (TEFRA 1982); the Deficit Reduction Act (DRA 1984); the Consolidated Omnibus Budget Reconciliation Act (COBRA 1985); and the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986).

Medicaid Expenditures after 1981 (Chapter II)

- In response to both the OBRA legislative changes and the economic recession of 1981-1982, Medicaid spending stopped growing. The inflation-adjusted spending increases of over 5 percent per year that occurred prior to 1981 were abruptly halted; Medicaid spending in inflation-adjusted terms was essentially constant between 1981 and 1984.

- Acute care received more of the brunt of cost containment efforts than did long-term care. The growth rates of spending on each fell from previous growth rates, but spending on acute care was curtailed more sharply.

- Because acute care services were more sharply reduced, more of the burden of spending reductions was associated with services used by adults and children and relatively less on services used by the aged and disabled.

- Both the 1981 OBRA legislative changes and the recession contributed to spending reductions. It is clear that the Federal government can influence the level of Medicaid spending through altering Federal matching rates. We estimate that the three-year savings from the federal matching rate reductions were $1.7 billion. This includes both the direct effect from lower matching payments and the indirect effect that reduced matching rates have on program expenditures.

- Evidence was also strong that the economic recession--by affecting the ability of States to purchase services for the poor--depressed Medicaid spending. Increased need arising from recession-induced unemployment, however, does not lead directly to higher spending, but rather appears to add to the queue of individuals who could potentially be served by the program. State per capita income, or ability to pay, determines how far States go in serving diverse newly needy individuals.

- States reduced Medicaid spending after 1981 by achieving substantially more control over hospital inpatient spending than ever before. States also restrained expenditures on physician services through strong controls on the growth in physician fees and other policies. Cost containment policies imposed on optional services (prescription drugs, dental care, etc.) also contributed substantially to controlling Medicaid spending. Finally, the rapid growth in both recipients and expenditures for intermediate care facilities for the mentally retarded (ICF-MRs) slowed dramatically suggesting that the boom associated with the certification of State institutions for the mentally retarded as Medicaid-certified ICF-MRs has subsided.

- With the exception of provisions facilitating the adoption of prospective payment systems for hospital inpatient care states' spending restraint after OBRA 1981 was due largely to policy options which had always been available under Medicaid regulations. Waivers permitting States to modify the freedom-of-choice requirements of Medicaid or to provide home and community-based services did not contribute to Medicaid spending reductions. The conclusion, it must be noted, applies only to the period studied (through 1984) and may not reflect later experience.

- Since Medicaid State spending is influenced systematically by Federal matching rates and the level of economic activity, the renewed upward trend in 1985 and 1986 is to be expected. However, inflation-adjusted growth rates will probably not return to previous levels because of State success in controlling inpatient hospital spending and the slowdown in the growth of the ICF-MR benefit. Structural changes to the Medicaid program could, of course, change this prognosis.

Recent Trends in Medicaid Eligibility (Chapter III)

- Medicaid covers families receiving Aid to Families with Dependent Children (AFDC). The OBRA 1981 tightened AFDC eligibility requirements and thus eliminated Medicaid benefits for many among the "working poor." In response, subsequent legislation provided States with the flexibility to gain Federal financial participation for persons in poverty who are not enrolled in AFDC, e.g., pregnant women and children who lack adequate health care coverage. National data on Medicaid enrollment and expenditures indicate that the post OBRA expansion have, to date, had only minor impacts on improving access to Medicaid coverage for persons in poverty.

- Though the number of Medicaid recipients, about 20 million, was almost the same in 1985 as 1975, there was a dramatic shift in the composition of the poverty population: an increased incidence of poverty among families and children and a decline in poverty among the elderly. Since Medicaid did not respond to this shift, poor children and families, for example, were less likely to have Medicaid coverage in 1985 than in 1975.

- The failure of AFDC benefit levels (eligibility thresholds) to keep up with inflation between 1975 and 1985 has been a major cause of the decline in Medicaid program enrollment for children and families. Because States retain wide discretion over AFDC benefit levels, and because the majority of Medicaid recipients are eligible through AFDC cash assistance, Congressional efforts to expand Medicaid coverage of non-AFDC families and children have only slightly moderated the impact of declining AFDC benefit levels.

- OBRA 1986 for the first time allows States to separate Medicaid eligibility for pregnant women and young children as well as the aged and disabled from the AFDC Supplemental Security Insurance (SSI) or Medicaid "medically needy" financial criteria. OBRA 1986 is thus a major test to determine whether or not States will choose

to expand Medicaid enrollment for pregnant women and children with incomes between the AFDC (or medically needy) level and the poverty threshold.

- In contrast to AFDC benefit levels, raises in Federal SSI benefit levels exceeded the rate of inflation between 1975 and 1985. As a result, Medicaid's coverage of the elderly and disabled poor has not eroded over time. However, the extent of Medicaid coverage of the elderly and disabled poor remains somewhat unclear because almost 40 percent of all aged Medicaid recipients use nursing home care, and nursing home recipients are not included in poverty statistics. Many poor elderly persons who are not in nursing homes do not have access to Medicaid coverage, particularly in States that do not supplement SSI payments. The 1986 OBRA legislation also permits States to cover all elderly below the poverty line.

The Impact of OBRA 1981 on Medicaid Enrollment (Chapter IV)

- The impact of OBRA 1981 accounted for a reduction of about 13 percent in Medicaid enrollment. Population growth and the economic recession, however, offset some of this impact resulting in a smaller net reduction of about 5 percent in Medicaid enrollment after OBRA 1981.

- The direct impact of the OBRA 1981 eligibility reductions on Medicaid costs in 1982 was approximately $900 million.

- Approximately half the individuals losing Medicaid eligibility were able to replace Medicaid with group health insurance. The remainder did not appear to obtain insurance coverage. The individuals losing Medicaid eligibility who did not obtain health insurance coverage were predicted to experience extremely large reductions in utilization of physician services, inpatient hospital services, and use of prescription drugs.

- The noninstitutionalized Medicaid population increased by slightly more than 200,000 people between 1979 and 1983. 1 percent increase During the same period there was a 37 percent increase in the U.S. poverty population. OBRA changes in eligibility, coupled with continued State limitations on increases in AFDC payment standards, resulting in a substantially reduced probability that individuals, particularly those in families with annual incomes above the poverty line, would be covered by Medicaid.

- Children and young adults were most likely to be affected by the changed environment. The number of children on Medicaid increased by less than 4 percent at the same time as the number of children in poverty grew by 35 percent. The likelihood of children being covered by Medicaid decreased, particularly among children in families with annual incomes above the poverty line.

- The number of young adults, primarily women, on Medicaid increased by almost 20 percent, but this increase was much less than the increase in the number of young adults in poverty. As with children, the likelihood of being on Medicaid declined. Again, this is particularly true of young adults with annual family incomes above the poverty line.

- In contrast to children and young adults, the number of elderly Medicaid recipients declined sharply, particularly for those aged 65 to 74. The proportion of elderly in poverty also declined. As a result fewer met Medicaid eligibility standards.

Hospital Reimbursement (Chapter V)

- State Medicaid programs responded rapidly to the opportunities offered by OBRA 1981 and subsequent Federal actions. Thirty States significantly changed their Medicaid hospital payment programs between 1981 and 1985. The trend was to base payment upon some standard external to the individual hospital such as the average

costs of peer hospitals, trends in input prices, or the industry average cost of treating a particular diagnosis.

- The movement toward new payment systems was paralleled by a reduction in the rate of increase in Medicaid hospital expenditures nationwide. States which initiated alternative reimbursement programs had lower rates of hospital expenditure growth than did States which made no changes in their programs. States clearly used the flexibility provided by OBRA 1981 to choose a system tailored to their particular circumstances.

- When rate-setting systems for inpatient hospital care were separated into Medicaid-only, some (but not all) payers, and all-payer systems, it was found that the Medicaid-only and all-payer systems both had significant cost-containment effects. The effect of the Medicaid-only systems was confined to the first full year of operation. The effect of the all-payer systems continued throughout the observation period.

- Selective contracting is attractive from a theoretical perspective, because it stimulates a hospital to declare a price which reflects efficient behavior (plus whatever minimum markup it may be able to negotiate). California's experience with selective contracting so far is encouraging. It has led to lower payment rates without evidence as yet of problems in quality of service, or of access to care.

- There are caveats, however, about the generalizability of that experience. First, California may have been successful in part because of its many high-cost/low-occupancy-rate hospitals; the conditions for success may become more difficult to achieve in subsequent negotiations. Hospitals may also bid higher rates over time as more of their costs become variable costs (as new decisions on staffing, wages, renovation, etc., must be made). This may lead to a higher proportion of hospitals deciding not to treat Medicaid patients.

Case Management (Chapter VI)

- OBRA 1981 gave States the opportunity to restrict recipient freedom of choice of provider and to establish primary care case management (PCCM) programs as a means not only of containing costs but also of improving service access and quality. Under PCCM, Medicaid recipients usually select (or are assigned) a primary care physician, who becomes their medical case manager. Thereafter, except in a true emergency, all care is provided or authorized by the case managing physician. Many States, including several of the largest, responded to the OBRA 1981 flexibility by establishing PCCM programs.

- PCCM implementation was slower than anticipated due to complexities in recipient enrollment, provider participation, and the attendant administrative burden of starting and operating a distinct service delivery model.

- All six PCCMs operational long enough for case study reported net savings per enrollee-year compared to their traditional fee-for-service Medicaid option; ranging from less than 1 percent for Utah's HMO program to 15 percent for Kansas' non-capitated program.

- PCCMs generally do not yet include all of the originally targeted recipients, so reported savings are a very small percentage of a State's total acute care costs; ranging from 0.5 percent for Nevada to 3.4 percent for Kansas.

- Available utilization analyses suggests that PCCM has redistributive effects:

  - Recipients previously without a medical home use more service.

  - Services to children generally do not decrease and the best evidence suggests a small increase for this population.

- Adult enrollees, the most likely to overuse services if not managed by a single physician, evidence the greatest declines in utilization.

- Except for laboratory and x-ray, which rose in three of four States where data was available, service utilization generally decreased as expected. Inpatient and outpatient hospital (including ER), physician office visits, and prescription drugs decreased.

- In some cases, the unexpectedly complicated PCCM enrollment process caused disruptions in recipients' existing physician-patient relationships or assignment to an inappropriate physician. But the fallout in terms of recipient satisfaction seems to have been negligible.

- Recipients seem generally satisfied with PCCM, especially recipients who had difficulty accessing care before PCCM because they lacked an established or appropriate medical home.

- As is the case for the findings on cost sharing that follow, the findings resulted from State case studies. Empirical evidence of PCCM effects is based on secondary analysis of findings from studies performed by the States themselves and therefore should be viewed cautiously.

Cost Sharing (Chapter VII)

- The use of recipient cost sharing in the form of modest copayments for medical services and goods has been a State option since Medicaid began in 1965. Although the first States did not adopt cost sharing until 1973, a total of 35 States have used it.

- States' decisions to implement cost sharing was generally motivated by a need to contain Medicaid expenditures, but some States cited

other reasons as well, such as a desire to promote self-sufficiency among public assistance recipients.

- The 1982 TEFRA legislation altered cost sharing provisions by setting aside the gross distinctions of categorically and medically needy, and of mandatory and optional services and introducing a whole set of finer distinctions that could be included and by allowing cost sharing charges for the categorically eligible recipients on most mandatory services. Several States dropped cost sharing after TEFRA, citing administrative complexity as the reason.

- Of the seven case study States with data, the savings to Medicaid from cost shifting (shifting service costs to recipients, thus lowering provider reimbursement payments by Medicaid) seem to be in the range of $2.50 - $15.50 per recipient per year.

- There is some evidence that cost sharing saves more in the short run than it saves over the long term. If cost sharing reduces preventive service use in a manner that causes subsequent use of high-cost services occasioned by foregoing earlier treatment, it may not produce savings in the long run.

- It is not clear what effects cost sharing has on providers. For those whose services are generally purchased at the time of supply (such as pharmacists) and who can charge copayments at that time, the burden of cost sharing is relatively limited. For providers whose charges are generally paid after the fact (such as hospitals), cost sharing includes the prospect of not recovering the copayment in addition to the added administrative burden of copayment collection.

- According to the States, administrative start-up costs are high but the administrative cost of an ongoing cost sharing program is much lower.

Home and Community-Based Care Waivers (Chapter VIII)

- By September 1985 there were 75 home and community care waiver programs in 42 States: 34 were targeted to the aged/disabled population; 35 served developmentally disabled and chronically mentally ill (DD/CMI) individuals; and 6 programs served combined populations (A/D-DD).

- About 70,000 Medicaid recipients were involved; one-third of developmentally disabled and two-thirds aged or physically disabled. About 1,100 participants were chronically mentally ill.

- Almost two thirds of the $257 million expanded on waiver services in FY 1985, was for DD/CMI cases, the group representing only one-third of all waiver recipients. The average annual cost to Medicaid per DD/CMI client was about $7,259 as compared with $2,008 per A/D recipient.

- Although Congress intended the waiver program's cost to be offset by corresponding reductions in Medicaid-borne institutional costs, this expectation of budget neutrality is probably not being met for some waiver programs.

- Only 2.4 percent of the aged and disabled waiver participants entered the program from nursing homes and only one-third of the DD/CMI population entered from ICF-MRs or [other] State institutions.

- States argue that the availability of waiver services "prevents or delays" impaired people from entering nursing homes. Four case studies in California and Georgia indicate that this assertion may not be accurate; the populations served were found to be at low risk of nursing home use.

- Even when properly targeted, waiver services do not seem successful in delaying nursing home admission. The evaluation of the California MSSP found that for the waiver population targeted correctly, i.e., for those that would have gone to a nursing home absent the waiver services, the MSSP services were not effective in preventing nursing home entry. The Georgia and IHMC case studies found similar results.

- Prior to their entry into a waiver program, most developmentally disabled waiver clients were already being served in community-based residential programs. Care for these clients was generally funded by the clients' SSI income and State funds, but financing shifted to Federally matched Medicaid dollars under the waiver program. Absent the waiver, these services may have continued to be financed with non-Medicaid dollars.

- These findings have limitations because they are based on four case studies and because most waiver programs have only been in effect three or four years. The ultimate effect of the waivers on long-term care delivery and financing may not be fully evident or may require most exhaustive analysis.

- Finally, the preliminary evaluation findings do not necessarily mean that the Section 2176 waiver program is bad Federal policy. Although the waiver programs examined did not meet the budget neutrality criterion, some others may, and the waiver programs seem to have great value to those who receive services.

Incentives for Family Care (Chapter IX)

- In formulating policies for financing long-term care services for the nation's elderly, one of the most fundamental issues is the relative contributions of government and family in meeting the demand for care. Policy judgments are constantly being made regarding how the level of public assistance should relate to the

ability and willingness of family members and other informal caregivers to also provide care.

- Many States pay family members [who] provide long-term care services, but usually not with Medicaid funds. These states have [had] to specify the conditions under which some family caregivers are eligible for payment, while others are not. These criteria vary widely from State to State.

- The primary Federal tax incentive to encourage family caregiving is the Child and Dependent Care Tax Credit, which was expanded in 1981 to include credits for day care for a disabled spouse or elderly dependent. However, only taxpayers who share a household with an elderly dependent may claim the credit, and only if all taxpayers in the household are gainfully employed.

- Idaho is the only State which has recently attempted to require the adult children of Medicaid recipients in nursing homes to contribute to the cost of their parents' care. However this initiative started was terminated after six months when the State Attorney General rendered an opinion that the law was not a "law of general applicability." Without a more specific definition of the legal inadequacy of Idaho's law, other States are not likely to enact relative responsibility programs.

How Has Medicaid Changed? (Chapter X)

- The intent of the original architects of Medicaid was to provide medical assistance for many of those who could not pay for their own medical needs. It has now become a much more narrowly targeted program.

- There has been a trend toward restriction of services to a basic benefit package, similar to limitations on health benefits provided by employers.

- Changes in eligibility requirements have reduced Medicaid participation by poor families and children, rather than the SSI-elderly and disabled. Despite increased poverty in the 1980s, children and families near the poverty line have experienced the most reductions in access to medical care.

- As a result, pregnant women and younger children not receiving Federal cash assistance are now [been] targeted as a high priority for Medicaid coverage. All states are required to provide coverage to pregnant women and children, regardless of family circumstances, with incomes below existing welfare levels. Great discrepancies exist across states, however, due to the wide variations in AFDC benefit standards.

- States also have authority to expand coverage of pregnant women and infants, as well as to the elderly, if their incomes are below existing poverty thresholds. This new flexibility has the potential to widen the differences across States in eligibility and coverage.

- It will be important to see whether the 1986 OBRA provisions allowing States to separate Medicaid eligibility completely from the AFDC or medically needy financial criteria stimulate major new coverage initiatives.

With costs rising 15 percent annually throughout the 1970s, Medicaid aroused budgetary concern. The program was therefore an attractive target for efforts to reduce the Federal budget in 1981. To limit Federal obligations and encourage States to control Medicaid spending, the Reagan administration's 1982 budget proposed to set a "cap" on annual rates of growth in Federal contributions to Medicaid financing. Alongside the cap, the administration proposed to give the States more flexibility in program design to achieve efficiency and spending control.

Responding to strong opposition from State governors, the Congress rejected the proposed cap on Federal spending. Instead, it took the more modest step of reducing--by 3 percent (1982), 4 percent (1983), and 4.5 percent (1984)--the share of Medicaid spending the Federal government would pay, if States exceeded specified expenditure targets. Congress also reduced Federal (and State) Medicaid liabilities indirectly by setting limits on welfare eligibility levels to which Medicaid is tied.

At the same time, Congress awarded the States greater flexibility in program design, following program reform proposals developed by the nation's governors and supported by the administration. Although OBRA fell short of their goals, the new law did eliminate several restrictions on program design and did incorporate most of the governors' reform recommendations. Some of the new freedom allowed States to reduce eligibility or service in ways previously prohibited. The bulk of the new options were not perceived as cuts, but were regarded as measures that would promote innovations in service delivery and more efficient use of Medicaid dollars.

OBRA's passage in 1981 (effective FY 1982) was a major but not the only stimulus for changes in the Medicaid program in the early 1980s. In late

1980, the nation began to slide into the worst recession since the Depression of the 1930s. As unemployment rates rose dramatically, State revenues fell significantly short of spending commitments. The pressure to cut Medicaid, one of the fastest growing programs in most States' budgets, was enormous and quite independent of Federal legislation.

In combination with the recession, however, OBRA laid the groundwork for some new approaches to Medicaid policy, in the short and long term. In the short-term, OBRA both added pressure on the States to control spending (with reductions in Federal matching rates if target growth rates were exceeded) and gave the States some new policy tools (mandated eligibility limits and optional changes in policy design). How did these actions affect State behavior? More specifically, did the options OBRA offered lead States to control spending more or differently than they otherwise would have done?

Over the long term, OBRA may have an even greater impact on State policy. Analysts have observed that historically most States' efforts to contain Medicaid costs have been limited to periods of fiscal crisis and characterized by a barrage of benefit and service cuts.[1] By promoting greater control over service use and innovations in health care delivery, OBRA aimed to give States the opportunity for more systematic and sustained mechanisms for containing costs. State initiatives in these areas may be reinforced (by example or practical overlap) by others' cost containment activities--the development of Preferred Provider Organizations in the private sector, or Medicare's adoption of a hospital prospective payment system. Over the long term, then, how are

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1. Randall R. Bovbjerg and John Holahan, Medicaid in the Reagan Era: Federal Policy and State Choices, Washington, D.C.: The Urban Institute Press, 1982.

States responding to OBRA and health system changes? Do their actions have the desired effects? Is Medicaid a better managed program as a result?

The Medicaid Program Evaluation aims to answer these questions as part of a broad analysis of changes in Medicaid since 1981. The evaluation involves a number of diverse studies conducted between October 1, 1983 and September 30, 1986, to address the following Medicaid policy areas: eligibility, freedom-of-choice waivers, cost sharing, Federal financial participation, hospital payment, home and community care waivers, and financial incentives for family care. The first four areas of evaluation tasks and this synthesis were done under contract with James Bell Associates, with subcontractors The Urban Institute, National Governors' Association, SysteMetrics, and Syracuse University. Abt Associates, with subcontractors Health Economics Research and Compass Associates, analyzed hospital payment changes. La Jolla Management Corporation, with subcontractor SysteMetrics, studied home and community care and incentives for family care.

This report represents a synthesis of these studies' findings, proceeding through a number of steps. The first step (Chapter II) is to document what changes occurred in Medicaid spending following OBRA's enactment, estimate how much of the change was due to OBRA and how much to the recession, and identify which policy options were responsible for the changes. In Chapters III and IV we look in detail at Medicaid eligibility policy over the last 10 years, identifying the factors responsible for changes, and describing their impact on Medicaid's ability to provide medical assistance to poor people. Chapter V focuses on hospital payment systems under Medicaid, examining the impact of

new forms of hospital payment on spending to date, and assessing case-study evidence on two of the most innovative systems--selective contracting and DRG systems.

Chapters VI, VII, and VIII examine States' responses to the new policy tools permitted by the recent legislation and use case-study evidence to examine their effectiveness. Chapter VI reports on the effects of loosening recipient "freedom-of-choice" restrictions and establishing primary care case management (PCCM) programs. Chapter VII traces the evolution and effects of cost sharing in Medicaid, including the influence of TEFRA provisions. Chapter VIII provides preliminary evidence on the effects of Medicaid 2176 home and community-based care waivers. Chapter IX addresses the issue of how public resources and resources within the families of elderly persons with long-term care needs might complement each other more effectively.

Chapter X presents the conclusions of the study team with respect to whether the intent of the 1981 OBRA and more recent legislation has been realized; if so, what have been the consequences for access and delivery of care; and, finally, what all this may portend for the future.

II. MEDICAID EXPENDITURES AFTER 1981

The changes in the Medicaid program wrought by the 1981 Omnibus Budget Reconciliation Act (OBRA) were designed to control the growth in Medicaid expenditures. This chapter compares the level and pattern of Medicaid expenditures in the 1981-84 period with those in the three-year period before passage of OBRA. The purpose is not only to document changes in the Medicaid program between the two periods but, more importantly, to identify how much of the change is due to OBRA and how much to the recession of the early 1980s. We address the important issue of whether State spending restraint is due to new authorities provided by OBRA or to policy options previously available. And we use our findings to assess what is likely to happen to Medicaid spending in the future, as Federal matching rates return to pre-1982 levels, on the assumption that the improvement in the economy continues.

Data Sources and Methodology

A number of data sources and approaches were used in the research that underlies this discussion. Many of the studies relied on the HCFA-2082 annual Medicaid expenditure reports, which provide detailed information by State on the number of Medicaid recipients and their expenditures for each service for

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This chapter summarizes findings presented in W. Davis and T. Gullo, "State Budget Priorities and Medicaid," MPE Working Paper 7.2; John Holahan, "The Effects of the 1981 Omnibus Budget Reconciliation Act on Medicaid," MPE Working Paper 7.3; John Holahan, "An Overview of Medicaid Acute and Long-Term Care Expenditures, 1978-1984," MPE Working Paper 7.6; Joel Cohen, "Success and Failure in Containing Medicaid Costs: Twelve States' Experience Between 1981 and 1982," MPE Working Paper 7.1; Stephen Zuckerman, "Medicaid Hospital Spending" The Effects of Reimbursement and Utilization Control Policies," MPE Working Paper 7.4; Joel Cohen, "Federal Matching Rate Reductions, the Recession, and Medicaid Spending," MPE Working Paper 7.5; and Joel Cohen, "Medicaid Policy and the Substitution of Outpatient for Physician Care," MPE Working Paper 7.7.

each eligibility group. We also developed a Medicaid-specific price index which allowed us to identify how much of the overall change in Medicaid expenditures was change in number of recipients, how much was underlying price inflation, and how much was change in services provided. We conducted two types of multivariate analysis to disentangle the effect of income and Federal matching rate reductions on Medicaid spending. We also reviewed State budgets in 17 States through the years 1981-1983 to see how Medicaid spending reductions compared with spending for other State services. Finally, we reviewed policy changes made by States throughout the country in order to understand what kinds of policies were associated with State success in achieving control over growth in costs.

What Happened to the Trend in Medicaid Spending after the Passage of OBRA?

In the period between 1978 and 1981, Medicaid spending grew by 16.1 percent per year in actual and 5.4 percent in inflation-adjusted terms, continuing a pattern that had existed for several years prior to 1978. Following the OBRA legislation in 1981, there was an abrupt break in this pattern. Actual Medicaid spending increased by only 7.5 percent per year between 1981 and 1984, and inflation-adjusted Medicaid spending was essentially unchanged. This change in spending patterns was widespread, with only five States failing to have lower real growth rates in the 1981-1984 period than in the prior three years (see Table II.1).

Much of the spending reduction after 1981 occurred in the first year. In all but 6 States growth in actual Medicaid spending between 1981 and 1982 was lower than the annual average for the 1978-1981 period; in 34 States inflation-adjusted spending declined; and in 11 States even actual spending

Table II.1

Percentage Changes in State Medicaid Expenditures, by State
1978-1984

State	1978 Expenditures (in millions)	Annual % Change 1978-1981		Annual % Change 1981-1984	
		Actual	Inflation-Adjusted	Actual	Inflation-Adjusted
United States	$17,706.9	16.09	5.35	7.54	-0.02
Alabama	191.5	14.20	3.69	8.16	0.51
Alaska	22.0	26.28	14.71	10.04	2.18
Arkansas	178.6	15.84	5.28	7.12	-0.54
California	2,286.0	15.78	4.86	-2.56	-9.62
Colorado	141.9	14.50	4.00	12.08	4.22
Connecticut	250.1	14.78	4.29	13.42	5.58
Delaware	30.3	21.80	10.52	7.56	0.15
District of Columbia	118.4	10.35	-0.29	24.17	16.05
Florida	255.5	24.68	13.13	16.71	8.54
Georgia	357.8	14.83	4.25	4.05	-3.51
Hawaii	76.6	12.59	2.07	6.52	-0.80
Idaho	38.1	16.22	5.60	3.35	-3.70
Illinois	967.8	14.41	3.72	5.18	-2.31
Indiana	271.4	18.13	7.34	12.98	4.94
Iowa	176.3	15.26	4.70	6.42	-1.06
Kansas	140.2	15.52	4.95	3.29	-3.88
Kentucky	198.1	22.49	11.07	10.25	2.51
Louisiana	290.2	14.34	3.96	16.59	8.15
Maine	107.8	12.98	2.62	10.02	2.35
Maryland	276.6	18.96	7.79	8.72	1.02
Massachusetts	826.4	10.96	0.59	5.56	-1.81
Michigan	895.5	13.95	3.32	7.14	-0.60
Minnesota	429.6	16.39	5.84	12.13	4.56
Mississippi	163.8	14.26	3.73	8.53	0.67
Missouri	181.0	24.74	13.23	11.14	3.38
Montana	46.8	23.03	11.74	3.54	-3.73
Nebraska	82.1	14.13	3.72	7.02	-0.48
Nevada	25.5	34.25	21.71	2.22	-4.85
New Hampshire	50.0	18.98	8.18	9.38	1.91
New Jersey	557.5	14.70	4.11	7.61	0.05
New Mexico	55.2	17.63	6.64	13.83	5.70
New York	3,114.4	16.89	6.07	10.82	3.14
North Carolina	285.9	18.81	7.84	8.40	0.85
North Dakota	36.8	17.82	7.06	18.34	10.28
Ohio	612.2	19.52	8.46	15.89	7.53

Table II.1 (continued)

State	1978 Expenditures (in millions)	Annual % Change 1978-1981		Annual % Change 1981-1984	
		Actual	Inflation-Adjusted	Actual	Inflation-Adjusted
Oklahoma	205.9	20.10	9.02	3.64	-3.69
Oregon	153.0	8.69	-1.25	5.87	-1.52
Pennsylvania	1,033.2	12.73	2.39	6.20	-1.01
Rhode Island	113.5	17.14	6.27	9.07	1.62
South Carolina	162.9	21.69	10.54	0.18	-6.85
South Dakota	39.7	21.66	10.58	7.91	0.49
Tennessee	263.8	17.16	6.42	7.86	0.17
Texas	773.9	14.99	4.50	7.60	-0.05
Utah	60.7	13.81	3.36	11.09	3.29
Vermont	45.4	15.96	5.31	5.95	-1.56
Virginia	259.0	18.96	8.01	5.69	-1.65
Washington	243.0	19.86	8.83	4.74	-2.62
West Virginia	75.5	18.72	7.59	2.71	-4.51
Wisconsin	529.8	15.96	5.42	3.31	-3.89
Wyoming	9.8	19.78	8.70	16.46	8.47

SOURCE: HCFA 2082 Medicaid Expenditure Report.

declined. Although overall inflation-adjusted spending increased again thereafter, averaging 1.3 percent a year between 1982 and 1984, the rate of increase was substantially below that of the pre-OBRA period.[1]

How Did Changes in Number of Recipients and Expenditures per Recipient, Respectively, Affect Total Spending?

Both the number of recipients and spending per recipient declined after 1981, but reductions in spending per recipient accounted for a much larger share of spending reductions (about 85 percent) than did the decline in the number of recipients.

The number of recipients fell by 0.7 percent annually between 1981 and 1984, after having risen slightly (0.1 percent per year) between 1978 and 1981. Most of the fall occurred in 1982, with a drop of 1.8 percent. By 1984, 35 States had fewer Medicaid recipients than they did in 1981.

The rate of growth in spending per recipient fell much more. Actual spending per recipient grew by 8.3 percent a year between 1981 and 1984, compared to 16 percent per year between 1978 and 1981. Inflation-adjusted spending per recipient increased by only 0.7 percent between 1981 and 1984, compared to 5.2 percent per year during the 1978-1981 period. Forty-one

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1. Inflation-adjusted spending is estimated here using the Medicaid-specific price index developed for this study. This index reflects the real cost of services purchased by Medicaid programs. If actual Medicaid expenditures are deflated by a general price index, such as the GNP deflator, estimated inflation-adjusted Medicaid spending growth is somewhat higher. The difference between the two sets of estimates is greater in the 1980s than earlier, reflecting the fact that medical care prices increased faster relative to general inflation after 1981 than before. The implication for public policy is that services used by the Medicaid population increased much less than the real resources absorbed from the economy by the Medicaid program. The Medicaid-specific price index is used in the remainder of this chapter, because we are interested in distinguishing between price effects and service effects.

States had lower growth rates in actual expenditures per recipient; 18 had reductions in inflation-adjusted expenditures per recipient; and 2 spent less per recipient in actual dollars in 1984 than they had spent in 1981.

How Were Changes in Medicaid Spending Distributed Between Acute and Long-term Care Services

The overall slowdown in Medicaid expenditures was accompanied by a shift away from acute care spending towards long-term care (defined as care in skilled nursing and intermediate care facilities, intermediate care facilities for the mentally retarded, mental hospitals, and home health care). Table II.2 illustrates the increasing relative importance of spending for long-term care.

The shift was beginning in the 1978-1981 period, but accelerated after 1981 (Holahan, MPE Working Paper 7.6). For example, between 1981 and 1984 actual acute care spending grew by only 6.1 percent per year; actual long-term care by 9 percent per year. In the 1978-1981 period the numbers were 15.3 percent and 17.0 percent, respectively.

In inflation-adjusted terms, acute care spending fell by 2.1 percent per year between 1981 and 1984; inflation-adjusted long-term care spending increased by 2.2 percent per year. The trends for number of recipients were in the same direction--an annual decline of 0.7 percent for acute care recipients versus an annual increase of the same percentage for long-term care recipients. Expenditures per recipient reflect these trends. In actual terms, spending per recipient for acute care declined by 1.5 percent per year; spending per recipient for long-term care increased by 1.4 percent per year. It is not clear how much changes in spending per recipient were caused by reduced utilization or by limits on provider reimbursement rates.

Table II.2

Medicaid Recipients and Expenditures: Acute and Long-Term Care
1978-1984

	Acute Care	Long-Term Care
Recipients, 1978 (thousands)	20,455	1,912
Expenditures, 1978 (millions)	$9,513	$8,194
Annual Change in Expenditures (percent)		
1978-1981 Actual	15.3	17.0
Inflation-Adjusted	4.2	9.0
1981-1984 Actual	6.1	9.0
Inflation-Adjusted	-2.1	2.2
Annual Change in Number of Recipients (percent)		
1978-1981	0.1	1.2
1981-1984	-0.7	0.7
Annual Change in Expenditures per Recipient (percent)		
1978-1981 Actual	15.2	15.6
Inflation-Adjusted	4.1	5.3
1981-1984 Actual	6.9	8.3
Inflation-Adjusted	-1.4	1.5

SOURCE: Constructed from data in Holahan (MPE Working Paper 7.6).

The combined shifts over the whole period led to a substantial change in the distribution of spending. In 1978 acute care accounted for 54 percent of total spending and long-term care 46 percent. By 1984 the proportions had almost reversed, with acute care having dropped to 51 percent and long-term care having risen to 49 percent.

What Categories of Medicaid Enrollees Were Most Affected by Spending Reductions?

Medicaid covers four broad categories of people eligible for cash assistance from Supplemental Security Income or Aid to Families with Dependent Children: the SSI-eligible aged; the blind and disabled (who are SSI-eligible by definition); AFDC-related adults; and AFDC-related children. States may choose to provide Medicaid coverage to people in these categories even if their family income exceeds cash assistance standards, primarily through medically needy programs.[1]

Table II.3 shows how the changes in Medicaid spending were distributed across each of these eligibility groups. The number of aged recipients and blind and disabled recipients fell by 2.2 percent and 0.6 percent, respectively, between 1981 and 1984. The number of AFDC children increased by 0.3 percent per year, the number of AFDC adults by almost 2 percent per year. The rate of growth in actual spending per recipient declined for all groups. However, inflation-adjusted spending continued to increase for the aged and blind and disabled, while declining for AFDC adults and children. These changes, as will be seen further below, reflect the types of services each

1. States may also choose to cover a small proportion of individuals who do not fall into these categories but meet other specified criteria. For the discussion here, we have grouped all Medicaid recipients into one of the four major categories.

Table II.3

Medicaid Recipients and Expenditures By Eligibility Group
1978-1984

	Aged	Blind and Disabled	Children	Adults
Recipients, 1978 (thousands)	3,362	2,676	10,047	4,370
Expenditures, 1978 (millions)	$6,316	$5,532	$3,231	$2,608
Annual Change in Expenditures (percent)				
1978-1981 Actual	17.0	20.0	8.6	13.8
Inflation-Adjusted	6.6	8.9	-1.9	2.8
1981-1984 Actual	8.2	8.8	5.0	5.2
Inflation-Adjusted	0.9	1.2	-2.8	-2.8
Annual Change in Number of Recipients (percent)				
1978-1981	0.0	2.9	-0.3	3.7
1981-1984	-2.2	-0.6	0.3	1.9
Annual Change in Expenditures per Recipient (percent)				
1978-1981 Actual	17.0	16.7	8.9	9.7
Inflation-Adjusted	6.5	5.9	-1.7	-1.0
1981-1984 Actual	10.6	9.5	4.8	3.3
Inflation-Adjusted	3.1	1.9	-3.1	-4.6

SOURCE: Constructed from data in Holahan (MPE Working Paper 7.6).

group uses. Between 1981 and 1984, actual spending per recipient on the elderly increased by 10.6 percent per year, and on the blind and disabled by 9.5 percent per year; these translate into small annual increases in inflation-adjusted spending. Actual spending on adults increased by only 3.3 percent per year, and on AFDC children by 4.8 percent; these translate into inflation-adjusted spending reductions of 3.1 and 4.6 percent, respectively.

In summary, for the aged and blind and disabled, inflation-adjusted spending continued to increase after 1981 despite reductions in the number of recipients. For AFDC adults and children, there were substantial declines in inflation-adjusted spending despite small increases in the number of recipients.

How Much Did OBRA, and How Much Did the Recession, Contribute to the Medicaid Spending Changes?

One of the most important changes made by the Omnibus Budget Reconciliation Act of 1981 was a reduction in Federal matching payments to the States. Prior to OBRA, the proportion of Medicaid service expenditures paid by the Federal government was based on the ratio of State to national per capita income in each State. The law required that this proportion be between 50 and 83 percent of each State's total spending, depending on the per capita income of the State. OBRA reduced the Federal payments States would otherwise be entitled to by 3.0 percent in 1982, 4.0 percent in 1983, and 4.5 percent in 1984. Thus, a State which otherwise would have had Federal payments equal to 50 percent of its total spending throughout this period would receive 48.5 percent in 1982, 48.0 percent in 1983, and 47.75 percent in 1984. The legislation permitted States to avoid these reductions if they took certain actions. First, the reductions were lowered by 1 percentage point each for

States that: operated qualified hospital cost-review programs and/or could document fraud and abuse recoveries equal to 1 percent of their Federal payments.[1] Second, States could offset the Federal reductions by the amount that total expenditures fell below a target set at a percentage (109 percent in FY 1982) of their projected spending. These Federal legislative changes increased the pressure on States to enact measures to contain costs.

At the same time as the OBRA legislation was implemented, however, the nation suffered a serious economic recession. A recession can be expected to have two opposing impacts on State Medicaid programs. First, downturns in the economy may be associated with increases in Medicaid spending because, other things equal, they expand the pool of individuals meeting the income requirements for program eligibility. This is likely to be particularly important for States with AFDC programs that cover two-parent families, whose eligibility is due to unemployment.

Second, recessions can affect the ability of States to generate tax revenues, which reduces their ability to finance Medicaid. Since Medicaid is one of the larger State operating-cost budget items—typically accounting for more than 10 percent of States' total spending--reductions in State revenues can be expected to stimulate efforts to reduce Medicaid spending, other things equal. There are good reasons, however, why Medicaid might be protected over other State-financed programs. Because a large proportion of total Medicaid spending is financed by the Federal government through matching funds, each dollar cut in Medicaid represents on average a State savings of only about 42 cents. States may prefer to cut spending in totally State-funded programs, where cuts by the States translate dollar-for-dollar into State savings.

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1. The reductions were also lowered by 1 percentage point for States with unemployment greater than 150 percent of the national average.

Moreover, it may be politically difficult to make large cuts in welfare programs in times of recession.

Regression analysis was used to disentangle the separate effects of these various factors (Cohen, MPE Working Paper 7.7). The unemployment rate was used to measure the effect of the recession on expanding the pool of eligibles; State per capita income was used to measure the effect of States' reduced ability to pay; Federal matching rates were used to measure the impact of matching rate reductions. In addition, two sets of dummy variables were used to measure other factors that might affect State spending.

Only State per capita income and the Federal matching rate were associated with States' Medicaid spending over this period (see Table II.4). A 1 percent change in the matching rate was associated with a 0.44 percent change in State Medicaid spending. A 1 percent change in State income per capita was associated with a 0.29 percent change in State Medicaid spending.

These results suggest that both the OBRA-mandated reductions in matching rates and the impact of the recession on States' ability to finance the program were significant factors in the slowdown in Medicaid spending growth that occurred between 1981 and 1984. The effect of the recession on eligibility, however, did not influence Medicaid spending over this period--suggesting that there was a surplus of potential eligibles throughout the period. What proportion of the potentially eligible population received Medicaid coverage depended on how far into the potential pool of eligibles States chose to go rather than how large the pool was. Recessions, in other words, expand the pool but do not necessarily assure there will be an expansion of enrollees. In fact, the decline in States' ability to pay makes it more difficult for them to increase enrollment.

Table II.4

Effects on Medicaid Expenditures per Capita
(percent change in Medicaid expenditures
associated with 1 percent change in
variable)

	Percent Change
Inflation-Adjusted per Capita Income	.29*
Federal Matching Rate	.44**
Unemployment Rate	.03

SOURCE: Cohen (MPE Working Paper 7.7).

*** Significant at the .01 level.
** Significant at the .05 level.
* Significant at the .10 level.

There was one other striking finding from this analysis. Before 1981, there was a clear trend in Medicaid spending which went consistently upward regardless of public policy changes or economic cycles. After 1981, this trend completely disappeared. This result strongly suggests some kind of fundamental change in the Medicaid program after 1981. Three such changes seem plausible: (1) the OBRA-mandated eligibility cutbacks, which may have universally reduced the number of people who otherwise would have been enrolled in the program; and (2) the increased flexibility granted under OBRA to institute various cost-containment provisions, the most prominent being prospective payment for hospital inpatient care, and (3) greater use of cost containment options available before OBRA, in part due to reductions in federal matching payments.

How Much Did the Federal Government Save in the OBRA Matching Rate Reductions?

The Federal government obtains savings from the matching rate reductions in two ways. It saves directly, even when States do not achieve spending reductions, because of the lower matching rates. It saves indirectly if the threat of the matching rate reductions induces the States to lower expenditures (and thus the Federal component).

The direct effects of the matching rate reductions are shown in Table II.5. Column 1 shows the gross reduction in Medicaid spending--that is, the amount the Federal government would have saved had the States not been eligible for any of the special exceptions to the matching rate reductions. These include State efforts to control fraud and abuse, the existence of hospital rate-setting programs, and high unemployment rates. The second column shows the total value of these offsets. The third column shows the

Table II.5

Direct Effects of OBRA Matching Rate Reductions

	Gross Reduction	Offsets	Incentive Rebate	Net Savings
1982	$528,830,545	$172,983,713	$201,377,841	$154,468,991
1983	773,905,719	126,625,742	316,526,357	330,753,620
1984	923,006,822	127,131,301	366,609,587	429,265,934
Total Reduction	$2,225,743,086	$426,740,756	$884,513,785	$914,488,545

SOURCE: Developed from Health Care Financing Administration Section 1903 (s) and (t) Reduction and Rebate Report, November 5, 1986.

effect of additional rebates to States which kept Medicaid expenditures below the OBRA-specified target. Incentive rebates were received by 31 States in 1982, 26 States in 1983, and 28 States in 1984. The final column summarizes the direct Federal savings from the net reduction in Federal matching contributions. These amounted to $914 million over the 3-year period.

Cohen's analysis of the effects of OBRA and the recession provides an estimate of the indirect effect of the matching rate reductions on State spending (MPE Working Paper 7.7). His estimates, together with the percentage matching rate reductions and actual spending levels, indicate that Medicaid expenditures in total were lowered by $1.5 billion over the three-year period, 1982-1984. The Federal share of this reduction was approximately $800 million ($190 million in 1982, $280 million in 1983, and $340 million in 1984). When these are added to the estimated direct Federal savings, we estimate total net Federal savings from OBRA to be approximately $1.7 billion over the 3-year period 1981-84.

How Did Medicaid Fare Relative to other State Programs?

Another approach to analyzing the effect of the recession and other developments on Medicaid spending is to examine how individual States treated Medicaid in the budget process. Were Medicaid programs cut back to the same extent as other programs? By more? By less? Were States that experienced more fiscal stress more aggressive in limiting the growth in their Medicaid spending? To answer these questions, Davis and Gullo examined Medicaid's place in State budget making for the FY 1980 to FY 1983 period in 17 States for which data was available: Alabama, California, Colorado, Idaho, Illinois, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York, Ohio, Pennsylvania, Texas, and Vermont (MPE Working Paper 7.3).

States were found to be relatively slow to control Medicaid spending--allowing Medicaid spending to increase faster than State spending as a whole over the period, much faster than spending on other programs[1] in FY 1980-82, and faster than spending in all programs except elementary and secondary education and criminal justice in FY 1981-82 (see Table II.6). In that year, when total State spending was dropping in inflation-adjusted terms, study States increased inflation-adjusted spending only for Medicaid (0.61 percent), criminal justice (3.1 percent), and elementary and secondary education (6.0 percent).

By FY 1982-83, however, States had stopped giving Medicaid preference. Medicaid spending grew substantially more slowly than total State spending and was one of only three programs allowed to decline. The three programs that declined (Medicaid, social services, and income support) were all welfare-related.

Twelve of the 17 States provided sufficient data to allow a comparison of spending patterns in fiscally stressed States with patterns in other States.[2] This comparison showed that the change in spending patterns appears to be largely traceable to the fiscally stressed States. In FY 1982-83, for example, States without fiscal stress allowed Medicaid spending to increase faster than total spending and than spending in all program areas except social services. In contrast, by 1982-83 fiscally stressed States held

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1. Other programs include: social services, income support, health (other than Medicaid), elementary and secondary education, higher education and criminal justice--60 percent of all State spending and a much larger share of non-administrative expenses.

2. States were classified as stressed when they experienced a large "expenditure gap," that is, when revenues fell more than 5 percent short of levels needed to maintain program expenditures at existing levels.

Table II.6

Average Real Changes in Spending, by Function

	1980-81	1981-82	1982-83
Total Expenditures	-0.27%	-4.34%	2.13%
Medicaid	(8.05)	(0.61)	(-1.00)
E&S Education	-2.37	5.97	0.94
Higher Education	-0.42	-2.94	0.60
Health	1.48	-2.94	0.60
Social Services	4.90[a]	-6.72	-1.00
Income Support	3.12	-0.36	-2.72
Criminal Justice	0.27	3.10	5.37

SOURCE: Data sources include state budgets, financial reports, and legislative reports. Because of differences of treatment of Medicaid expenditures among states, Medicaid figures reported here are HCFA data adjusted for state fiscal years.

a. Kansas has been excluded from this average because of peculiarities in its 1980 Social Service figures.

Medicaid spending (along with spending on other welfare-related programs) down in real terms, even though total State spending was growing.

Medicaid's place in State budgets suggests that: (1) States find Medicaid an attractive area to spend (or a difficult area to control), but (2) States can control Medicaid spending when they have to. Medicaid's attractiveness relative to other programs derives in part from the open-ended Federal match in funds available to finance health care. Because of this match, the State can buy far more than a dollar's worth of care for every dollar it spends. When services overlap, it can also buy Medicaid-covered services more cheaply than services in areas with little Federal funding. As a result, then, not only is Medicaid spending likely to increase faster than spending in other areas (with less favorable or no Federal funds), but Medicaid spending may also absorb services from other program areas (like health or social services), where the latter are more heavily State-financed.

At the same time these factors encourage Medicaid spending, other factors make Medicaid spending difficult to control. In contrast to other State activities, Medicaid entitles people to service and assumes liabilities for services used at specified prices, rates, or, for some services, costs. Medicaid expenditures, therefore, are a function of beneficiaries' and providers' behavior; these are less easy to control than State appropriations. Medicaid spending reductions are also more prone to legal challenges. Medicaid's attractiveness and complexity, then, help explain its relative growth. But the reversal of that pattern by 1983 suggests that when fiscal pressure makes it essential, States can and will control Medicaid spending.

How Did Medicaid Spending Changes Vary across Services?

Medicaid provides coverage for several different kinds of health services. The services differ in both their importance to the program and States' ability and willingness to control their growth (Holahan, MPE Working Paper 7.6). Table II.7 provides information on expenditure increases for the 1978-1984 period for each major service category. As can be seen, spending reductions were widespread, affecting all services.

Hospital inpatient care is by far the most important acute care service covered by the Medicaid program. States had been limited prior to 1981 in their ability to adopt hospital reimbursement systems other than Medicare's "reasonable cost" system. The OBRA legislation eliminated the requirement for "reasonable cost reimbursement" and permitted States to set ceilings on rates of payment that are independent of what a particular hospital spends or of increases in the costs of goods and services used by the hospitals. Between 1981 and 1984, the number of States using prospective payment systems grew from 13 to 35. In addition, States became increasingly aggressive in adopting utilization control policies such as precertification of admission, second-opinion programs for surgery, and limits on hospital stays.

As a result, actual spending growth for hospital inpatient care fell from annual rates of increase of 14.7 percent prior to 1981 to 6.7 percent thereafter. Some of the reduction in expenditure growth rates was due to a drop in recipients (about 2 percent per year); but most is attributable to a reduction in spending growth per recipient, which fell from an annual rate of growth of 15.2 percent to 9 percent per year after 1981. The drop in spending per recipient reflects both a drop in the underlying rate of hospital input price inflation and a real expenditure growth reduction--from 3.8 percent

Table II.7

Medicaid Recipients and Expenditures, By Service - 1978-1984

	Expenditures (in billions) Actual Dollars			Recipients		Expenditures per Recipient Actual Dollars		Expenditures per Recipient Inflation-Adjusted Dollars	
	1978	% change 1978-1981	% change 1981-1984	% change 1978-1981	% change 1981-1984	% change 1978-1981	% change 1981-1984	% change 1978-1981	% change 1981-1984
All Services	17,707	16.1	7.5	0.1	-0.7	16.0	8.3	5.2	0.7
Hospital Inpatient Care	4,896	14.7	6.7	-0.5	-2.0	15.2	9.0	3.8	0.9
Physician Services	1,698	11.0	2.0	0.1	-0.4	10.9	2.4	0.1	-5.4
Hospital Outpatient Care	1,015	17.5	10.7	3.7	0.6	13.3	10.0	2.0	1.9
Prescription Drugs	1,056	14.5	8.2	0.2	-0.7	14.3	8.9	5.1	-2.1
Dental Care	389	13.0	-5.5	5.6	-1.3	7.0	-4.2	-2.7	-10.5
Other Optional Services	460	33.0	5.8	12.5	0.5	18.3	5.3	7.3	-3.5
Nursing Home Care	6,184	12.3	7.7	0.2	-0.3	12.1	8.0	2.2	1.2
Intermediate Care Facilities — Mentally Retarded	1,232	35.4	11.5	12.2	-2.6	20.6	14.5	10.0	7.3
Inpatient Mental Health	579	75.4	6.1	-3.4	-4.0	19.4	10.4	8.9	3.5
Home Health (includes Home- and Community-Based Waivers)	199	28.2	23.1	2.6	5.9	25.0	16.3	13.4	8.1

SOURCE: Holahan (MPE Working Paper 7.6).

between 1978 and 1981 to 0.9 percent between 1981 and 1984. When it is remembered that the Medicare hospital deductible--which the Medicaid program pays for joint Medicaid/Medicare beneficiaries--increased between 1981 and 1984, these reductions in expenditure growth represent an extraordinary degree of success in controlling hospital expenditures by State Medicaid programs.[1]

Physician service expenditure growth also fell dramatically. Prior to 1981, actual expenditures on physician services had grown by 11 percent per year. Between 1981 and 1984, these expenditures grew only by 2 percent per year. Some of this slowdown reflected a small drop in recipients, but most of it reflects a slowdown in expenditures per recipient. These grew by only 2.4 percent in actual dollars between 1981 and 1984, as opposed to 10.9 percent per year before 1981--which translates into an inflation-adjusted reduction of 5.4 percent per year after 1981. States have always been reasonably aggressive in controlling physician fees; these kinds of policies continued after 1981. Data developed for this project indicate that Medicaid physician fees fell relative to Medicare fees, which are Federally determined, in virtually every State between 1981 and 1984.

Both reimbursement levels and utilization policies have a significant impact on physician service utilization and costs under the Medicaid program (Cohen, MPE Working Paper 7.7). A 1 percent reduction in the ratio of Medicaid to Medicare fees, for example, is associated with a .5 percent reduction in both total spending and spending per recipient. In addition, placing limits on the number of visits allowed under the program lowered total

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1. As will be discussed in Chapter V on hospital reimbursement, States' use of prospective payment systems was a key factor in reducing these growth rates.

spending by 8 percent, through a reduction in spending per recipient; coverage of routine physicals appeared to increase total spending by 15 percent, by increasing the number of service recipients.

Actual hospital outpatient expenditures grew much faster than those for physician services in the pre-OBRA period (17.5 percent vs. 11.0 percent per year). This pattern continued between 1981 and 1984, with annual increases in hospital outpatient spending of 10.7 percent per year vs. 2.0 percent for physician services. Increases in expenditures per recipient are principally responsible for these large increases. After 1981, actual hospital outpatient expenditures per recipient increased by 10 percent per year. While this represents some decline in the rate of increase compared with prior years, it primarily reflects a reduction in the underlying hospital cost inflation. Inflation-adjusted outpatient expenditures per recipient continued to grow at about 2 percent per year. The Cohen work (MPE Working Paper 7.7) shows clearly that lower physician fees result in both lower levels of physician expenditures and greater use of hospital outpatient departments. Thus, real declines in the rate of growth in physician services are contributing to the increase in hospital outpatient care.[1]

Spending on prescription drugs fell from an annual rate of 14.5 percent to 8.2 percent after 1981. Some of the reduction reflects a decline in the number of recipients; however, most is attributable to a decline in inflation-adjusted expenditures per recipient for prescription drugs. States have been particularly aggressive in adopting policies such as copayments, limits on

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1. Whether hospital cost controls are also contributing by pushing some services that used to be done on an inpatient basis into the outpatient department was not addressed in the study.

numbers of prescriptions, types of drugs covered, etc. in an effort to control prescription drug expenditures. The result was a 2.1 percent reduction in inflation-adjusted spending per recipient after 1981.

Spending on dental care and other optional services also fell dramatically after 1981. Actual expenditures for dental care fell by 5.5 percent after having increased by 13 percent per year. Actual spending on other optional services increased by only 5.8 percent per year after 1981 in contrast with an increase of 33 percent per year before. In both instances the number of recipients either grew at a substantially slower rate than prior to 1981 or actually fell. More importantly, however, there has been an inflation-adjusted reduction in expenditures per recipient of 10.5 percent per year for dental care and 3.5 percent for other optional services. Dental care and other optional services have long been a target for States in times of fiscal stress. This era was no different; the reductions reflect widespread State cutbacks.

Nursing home care, including skilled nursing facilities and intermediate care facilities, is the largest component of State Medicaid spending. Because it has historically been such an important component of State Medicaid budgets, States have been aggressive for a long time in their efforts to control these outlays. Prospective payment systems for nursing home care have been in place in most States for a long time, and an increasingly large number of States have imposed limits on the growth in the supply of beds. As a result, spending growth declined, but the difference in growth rates before and after 1981 were not as large as we have observed for other services (12.3 percent vs. 7.7 percent per year). The number of nursing home care recipients fell by 0.3 percent per year between 1981 and 1984--despite increased aging of

the elderly population. Spending per recipient fell from annual rates of growth of 12.1 percent to 8 percent in actual dollars and from 2.2 percent to 1.2 percent in inflation-adjusted dollars.

Intermediate care facilities for the mentally retarded (ICF/MRs) have for several years been the fastest growing component of the Medicaid program. Between 1978 and 1981, expenditures on ICF/MRs grew at rates of over 35 percent per year. This reflected a large increase in recipients (in most cases due to shifts from wholly State-funded institutions to Medicaid-certified facilities) and an increase in expenditures per recipient of over 20 percent per year. Spending on ICF/MRs slowed substantially after 1981. Spending growth, however, remained at 11.5 percent per year in the latter period. The number of ICF-MR recipients plateaued, suggesting that the process of certifying State-owned institutions as ICF-MRs, had been completed by the early 1980s. The growth in spending per recipient remained rapid, however, reaching an average annual cost of $32,960 in 1985, because of more lenient reimbursement for ICF-MRs and the substitution of smaller facilities for large institutions.

Home health care is now the fastest rising service component of the Medicaid program. However, States have not historically spent a great deal of money on this service. Although they have been permitted for many years to cover noninstitutional long-term care services, few States have made extensive use of this benefit. The primary reason appears to be concern that costs could easily explode; thus, a large number of limits--for example, limiting benefits to people needing short-term skilled nursing services, limits on number of visits, and low fee schedules--have been employed to control the use of the home health benefit. Despite these controls, the growth in actual

expenditures during the 1978-1981 period was relatively rapid, 28.2 percent per year. After 1981, the growth rate remained almost as high, averaging 23.1 percent per year. Part of this growth was due to increases in the number of recipients (almost 6 percent per year between 1981 and 1984). Part was real growth in service use (averaging 8.1 percent a year).

Was Success in Controlling Costs Due to the Provisions of OBRA or to Policies that Were Already Available to States?

Within the ground rules established by Federal law and policy, States have always been able to affect eligibility levels (through their determination of AFDC eligibility levels or "payment standards"); to limit payments to providers (with the important exception of hospitals); and to limit days or visits covered. For 1982 and beyond, OBRA gave the States several new means for containing costs.

Some new cost-containment measures legislated by OBRA were a matter of Federal law and therefore mandatory. For example, Federal law prohibited States from providing AFDC (and thereby potentially Medicaid) coverage to 19-21 year olds attending school and to persons whose earned income exceeded specified amounts; reduced the income States could "disregard" in determining eligibility; and established uniform limits on assets people could have and be eligible for AFDC/Medicaid.

Other OBRA changes were at State option. On eligibility, States were allowed (but not required) to cover persons ages 18 to 21 not receiving AFDC who would be eligible for AFDC if they were under age 18 or in school, and to vary the scope of "medically needy" coverage for different categories of eligibles. On provider reimbursement, States were, as described above, allowed greater leeway to control payments to hospitals. While States could depart

from reasonable cost principles prior to OBRA (with HCFA approval), the new law allowed a broader array of acceptable payment methods and HCFA accepted more than instructed State policy choices. On delivery and use, OBRA loosened the interpretation of "freedom of choice" by allowing States to enter into competitive bidding to purchase laboratory services or medical supplies, to restrict to specified providers (or "lock in") recipients identified as overusers, and to ban from the program (or "lock out") providers delivering excessive service or poor quality care. In addition, States were allowed to seek waivers from HCFA of freedom of choice and other requirements to establish organized delivery systems--e.g., primary care networks or case management systems. Use of organized systems was further encouraged by legislative changes facilitating HMO enrollment for Medicaid beneficiaries. On long-term care, States were allowed to seek waivers (of State-wideness and other requirements) to establish home- and community-based service programs, as long as program costs under the new program did not exceed estimated program costs in its absence.

While these new flexibilities (with the important exception of eligibility changes) allowed States to pursue cost containment and program efficiencies rather than simple benefit reductions, they do not appear to have been the primary factor in allowing States to control their costs after 1981. Rather, success in cost containment appears to be due to aggressive use of a wide range of cost-containment policies that had been allowable all along (Cohen, MPE Working Paper 7.1). These include controls on physician fees, prior authorization of hospital admission and limits on lengths of stay, prospective payment for nursing home care, limits on the growth in nursing home beds, copayments

for prescription drugs and other optional services, restrictions on coverage of optional services, and others.

Reductions in physician fees were at least partially responsible for the real reduction in physician expenditures (Cohen, MPE Working Paper 7.7). Prior authorization policies and prospective payment systems for hospital care also reduced Medicaid expenditures for hospital inpatient services (Zuckerman, MPE Working Paper 7.4). Other research has also shown that prospective payment systems for nursing home care and limits on the growth in nursing home beds have played a major role in slowing growth in Medicaid spending for nursing home care. An overview of Medicaid policy implementation and expenditure patterns (Holahan, MPE Working Paper 7.6) has demonstrated that a wide range of policies--such as copayments and prescription drugs and widespread restrictions on coverage of optional services--seem to be associated with substantial real reductions in spending on optional services. It has also been shown that the more successful States were those that adopted a broad spectrum of cost-containment policies, and placed particular emphasis on containing costs of institutional services of one kind or another (Cohen, MPE Working Paper 7.1).

In contrast, States' use of new OBRA provisions do not as yet seem to have had a major impact on spending patterns.[1] Two of the most prominent delivery changes authorized by OBRA, for example, the freedom-of-choice amendments and the home and community-based waivers, do not seem to have had major impacts on expenditures (see Chapters VI and VIII below).

Provisions pertaining to primary care case management arrangements were perhaps the most significant of the freedom-of-choice waiver programs. The

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1. A major exception, as noted previously, was OBRA's authority to adopt prospective payment systems for hospital inpatient care.

intent was to assure that one physician or group of physicians (or HMO) would act as managers of the case, thereby reducing the costs of acute care services by reducing "doctor-shopping" and reliance on expensive teaching institutions for routine outpatient care. Today, several primary care case management systems are operational. As of September 30, 1986, 22 States had submitted 42 applications to establish general primary care case management systems.[1] HCFA approved 28 of these proposals, of which 20 became operational and 17 are still in operation. In mid-1986, 17 programs were serving almost 800,000 Medicaid beneficiaries--about 5 percent of total monthly enrollees--and most of the enrollees are in 5 programs (Colorado, Kentucky, Michigan, Pennsylvania, and Wisconsin). These programs were too small and were developed too late to have had an impact on spending reductions between 1981 and 1984. It is not clear whether they will have a larger impact in the future.

The intent of the OBRA waivers of various Medicaid requirements--to allow States to cover home- and community-based long-term care services under very different conditions than had been previously allowed--was to promote these services as substitutes for institutional long-term care without increasing Medicaid costs.[2] Since the passage of this legislation, the administration has been extremely concerned about the potential for cost explosion. Congress and HCFA have established criteria for assuring that total program costs for home- and community-based care, other noninstitutional services, and institutional services do not increase. Principally because of these limits on overall expenditures, the waiver provision has had relatively little impact to

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1. See Chapter VI for a detailed discussion.

2. See Chapter VIII for a detailed discussion.

date. Once again, the programs are too small and were developed too late to have had an impact on the spending reductions we have observed between 1981 and 1984.

Is Spending Restraint Likely to Continue after 1984, or Will it Return to Earlier Spending Trends?

The results of both the Cohen (MPE Working Paper 7.5) and the Holahan (MPE Working Paper 7.3) analyses presented earlier suggest that both income and Federal matching rates are important determinants of Medicaid spending in both the short and long runs. They also indicate that the historical upward trends in spending unaccounted for by income and Federal matching rates appear to have leveled off. The latter provides good reason for believing that Medicaid spending will not return to historical rates of growth. The former, however, provide reasons for also believing that spending will not continue to stay constant in real terms. Federal matching rates were increased after 1984, returning to pre-OBRA levels. In addition, the economy has improved since 1983. Both should contribute to increased Medicaid spending.

Structural changes not accounted for in the analyses also suggest that Medicaid spending should rise. One such structural change is the home- and community-based waiver program, which may experience increased spending pressures in coming years. This is particularly true in light of recent COBRA legislation liberalizing many provisions of that program. Furthermore, recent legislation has liberalized various eligibility provisions, permitting States to provide increased coverage to pregnant women and children and to all elderly individuals who have incomes below the poverty level.

Even so, Medicaid spending growth is unlikely to return to previous rates. As we have discussed above, States have been very successful in

developing new payment systems for hospital and nursing home care and in implementing various methods of controlling utilization. In addition, the rapid growth in spending on intermediate care facilities for the mentally retarded seems to have subsided.

Why Does Medicaid Spending Vary So Much Across States?

Medicaid spending levels per capita differ widely across States. Many factors can be expected to lead to such differences--including differences in State ability to pay (as measured by per capita income); differences in the price they pay out of State funds (as measured by the Federal matching rate); differences in State spending preferences (as measured by State dollars spent on in-kind welfare programs); differences in population characteristics; and differences in the supply of providers.

To identify the relative strength of these determinants of State Medicaid spending, a regression analysis was undertaken as part of the acute care/long-term care expenditure analysis, using cross-section data from 1979 to 1982 (Holahan, MPE Working Paper 7.6).

An increase of 1.0 percent in State inflation-adjusted income per taxpayer, other things equal, resulted in an estimated increase in total Medicaid spending from 1.2 percent to 1.7 percent. A 1.0 percent increase in the Federal matching rate, other things equal, resulted in an estimated increase in Medicaid spending of 1.0 to 1.3 percent. These estimates are larger than the ones in Table II.4 because they reflect adjustments to long-term differences across States rather than to temporary cyclical changes. Consistent with the changing spending patterns noted earlier, the response of long-term

care spending to both income and Federal matching rates is stronger than for acute care.

The results strongly confirm that spending differences are related to a State's ability to pay--that is, the higher the State's income, the higher its spending on Medicaid services, other things equal. Higher income States have fewer people in poverty, but the strong relation between the income variable and spending suggests that higher income States spend more despite lower levels of need. The results also indicate that Medicaid spending levels are higher in States with a large physician supply. This suggests that the poor have greater access to, and therefore use more, services where physicians are in abundance.

The results also confirm that States with higher Federal matching payments have higher levels of Medicaid spending, other things equal. Federal matching incentives--which vary inversely with State incomes--are, therefore, effective in reducing the extent of interstate variation in Medicaid spending that otherwise would have occurred. The higher Federal matching rates in low-income States, however, are insufficient to offset entirely the effect of State per capita income.

Two demographic characteristics were found to be related to Medicaid spending: education (the percentage of the population that finished high school) and race (the percentage that was nonwhite). Lower percentages finishing high school and higher percentages of nonwhites are associated with higher Medicaid spending, at least for acute care. There also were substantial regional differences in spending even after controlling for variations in income, Federal matching rates, and demographic characteristics. The East had higher levels of spending compared with all other regions, indicating the

possibility of more tolerant political attitudes toward the Medicaid program than elsewhere in the country.

Summary

This chapter has summarized the major changes in the growth and composition of Medicaid expenditures since 1981. Real Medicaid spending adjusted for inflation had been increasing at 5 percent per year prior to 1981. This growth was abruptly halted. From 1981 to 1984 Medicaid spending remained essentially constant in inflation-adjusted terms. The composition of Medicaid expenditures changed because the cost containment efforts created by this halt in expenditure growth were directed unequally, more at acute care than at long-term care. While growth rates of spending in both areas were reduced, the level of spending on acute care was actually reduced. In the post-OBRA period, inflation-adjusted spending on acute care fell by more than 2 percent per year; while spending on long-term care increased by 2.2 percent per year.

Due to these unequal spending growth rates, certain categories of Medicaid enrollees were more affected than others. Expenditures on acute care services were more sharply reduced than were long term care. Thus expenditures on adults and children, relatively heavy users of acute care, were more affected than expenditures on the aged and disabled. Thus, between 1981 and 1984 despite a slight increase in the number of adults and children recipients, inflation-adjusted spending decreased by 3.1 percent per year for adults and decreased by 4.6 percent per year for children.

Given these effects of the spending reduction, what were the causes of this reduction? Both the OBRA Legislative changes and the economic recession of 1981-82 affected this reduction. Research in this project clearly

demonstrated that the Federal government can influence the level of Medicaid spending through altering Federal matching rates. Evidence was also strong that economic recessions--by affecting the ability of States to purchase services for the poor--depress Medicaid spending. The increased need for services arising from recession induced increases in persons in poverty does not lead directly to higher spending, but rather appears to add to the queue of needy individuals who could be covered by the program. State per capita income, or ability to pay determines how many of these needy individuals States will choose to serve.

In examining the considerable variation across States in Medicaid spending levels, it was found that over the long term state per capita income is the dominant factor in setting spending levels. Federal matching contributions--which vary inversely with per capita State income--partially offset the effect of income, reducing the Medicaid spending differential between poor and rich States. Finally, regional differences in Medicaid spending levels not associated with income, demographic, or environmental factors are very large, suggesting that regional political attitudes toward the Medicaid program influence spending levels.

During the post-OBRA period, how did Medicaid fare relative to other state programs? On average Medicaid spending was not cut as much as other State programs. However, in states under severe fiscal stress Medicaid spending was reduced proportionately more than other services. This suggests that Medicaid is a service States prefer not to cut, but one that can be cut substantially if the economic situation gets bad enough.

How did Medicaid spending vary across services? States achieved their reductions in Medicaid spending after 1981 by achieving substantially more

control over hospital inpatient spending than ever before. States also restrained expenditures on physician services through strong controls on the growth of physician fees and other policies. Cost containment policies imposed on optional services (prescription drugs, dental care, etc.) also contributed substantially to controlling Medicaid spending. Finally, the rapid growth in both recipients and expenditures for intermediate care facilities for the mentally retarded slowed dramatically, suggesting that the boom associated with moving individuals from wholly state-funded institutions to Medicaid-certified facilities may be over.

We have seen that OBRA (as well as the economic recession) provided incentives for the States to restrain Medicaid spending. This restraint in spending was largely carried out by using policy options which were available prior to OBRA 1981. A principal exception to this was the OBRA provision permitting the adoption of prospective payment systems for hospital inpatient care. Waivers permitting States to modify the freedom-of-choice requirements of Medicaid or to provide home and community-based services did not contribute to the Medicaid spending reductions of the period studied.

Is this Medicaid spending restraint likely to continue? Since Medicaid State spending is influenced systematically by both Federal matching rates and the level of economic activity, the renewed upward trend in 1985 and 1986 was to be expected. However, growth rates were not likely to return to their previous levels because of State success in controlling hospital inpatient spending and the slowdown in the growth of the ICR-MR benefit. Structural changes in the Medicaid program--such as liberalization of the provisions of the home and community-based care waivers or expanded Medicaid eligibility--could, of course, change this prognosis.

III. RECENT TRENDS IN MEDICAID ELIGIBILITY

Eligibility policy is the gatekeeper to the Medicaid program. Eligibility for Medicaid is also incredibly complex. First, eligibility rules for AFDC and SSI cash assistance govern eligibility for about four out of five Medicaid enrollees. Changes in AFDC and SSI eligibility policies, at both the Federal and State levels, have direct impacts on Medicaid program enrollment and expenditures. The number of options which States have in the design of their AFDC cash assistance programs and in how they choose to supplement Federal SSI benefits are many and varied. Second, Federal law mandates States to provide Medicaid coverage for certain groups of persons who are not receiving cash assistance through AFDC or SSI, and allows States considerable flexibility to cover additional groups at their own discretion. Thus, it is difficult enough just trying to understand how eligibility for Medicaid works, without even attempting to figure out how changes in these interacting eligibility rules for AFDC, SSI and Medicaid actually affect program enrollment and expenditure trends.

Nonetheless, an understanding of Medicaid eligibility policy is critical to understanding basic trends in the Medicaid program. This chapter examines the most important developments in Medicaid eligibility policy over the last ten years, and describes the impact which these developments have had on the ability of the Medicaid program to provide medical assistance to poor people.

This chapter summarizes findings presented in Ian Todd Hill, "Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA and DEFRA Provisions, and State Responses" (MPE Working Paper 5.2) and Marilyn Rymer and Brian Burwell, "Medicaid Eligibility: Analysis of Recent Trends and Special Populations" (MPE Working Paper 5.6).

Data Sources and Methodology

To document how States have changed their eligibility policies, a variety of sources were used:

- Characteristics of State Plans for AFDC, Office of Family Assistance, 1978-1985;
- State Medicaid Program Characteristics, Health Care Financing Administration, 1982-1984;
- The Medicaid and Medicare Guide from the Commerce Clearing House;
- Catalogue of State Medicaid Program Changes, National Governors' Association;
- Selected Characteristics of State Supplementation Programs, Social Security Administration, 1977-1986; and
- The Maternal and Child Health Data Book from the Children's Defense Fund.

HCFA's 2082 data were the main source for the estimates of changes in the levels and distribution of Medicaid enrollment and expenditures across groups, supplemented by SSI enrollment information from SSA. Some analyses of the characteristics of selected enrollment groups were conducted using HCFA's Tape-to-Tape data set.

How Have State Eligibility Policies Changed?

After passage of the legislation creating the SSI program in 1972, Federal provisions affecting Medicaid eligibility were left largely untouched for many years. Then, starting in 1981 and continuing through 1986 Congress amended the eligibility provisions of Title XIX as part of its budget reconciliation legislation. First OBRA (1981), then TEFRA, DEFRA, COBRA, and OBRA (1986) each included changes related to Medicaid eligibility, as documented in Table III.1 (Hill, MPE Working Paper 5.2). This legislative series both contracted and expanded Medicaid eligibility. Coverage of some

Table III.1

Federal Legislation Affecting Medicaid Eligibility, 1981-1986

OBRA 1981

--Limited gross income for AFDC recipients to 150% of State need standard
--Limited and restructured earned income disregards for working AFDC recipients
--Instituted nationwide uniform resource restrictions for AFDC recipients
--Expanded AFDC coverage of unemployed parent to "principal earner"
--Restricted AFDC cash assistance for pregnant women with no other children to beginning in 6th month of pregnancy
--Limited AFDC children eligible for cash assistance to those under age 19
--Provided States with greater flexibility in establishing medically needy programs by allowing targeted medically needy coverage for only pregnant women and children
--Provided States with greater flexibility in establishing Kibicoff children coverage by allowing them to set the upper age limit for full coverage at 18, 19, 20, or 21 years

TEFRA 1982

--Provided States with the option of covering disabled children under age 18 living at home if cost of care at home is no more expensive than institutional care
--Provided States with the option of denying Medicaid to SSI-related persons in institutions who dispose of their homes for less than fair market value within two years before applying for Medicaid

DEFRA 1984

--Increased gross income limit for AFDC cash assistance to 185% of State need standard
--Extended the $30 earned income disregard for AFDC from 4 months to 12 months
--Expanded work expense deductions for part-time workers and resource limits for all AFDC recipients
--Extended Medicaid coverage for 9 months to working families who lose AFDC eligibility because of earnings
--Provided States with the option of extending Medicaid for another 6 months to AFDC recipients losing AFDC eligibility because of earnings
--Required States to extend Medicaid to (1) first-time pregnant women who would be eligible for AFDC if the child were born and (2) pregnant women in families with principal wage earner unemployed
--Required States to phase-in Medicaid to all financially eligible children born on or after 10/1/83 up to age 5 regardless of family structure (so-called Ribicoff children)
--Increased asset limits for SSI recipients for period from 1985 through 1989

COBRA 1986

--Required States to cover under Medicaid all low-income pregnant women meeting AFDC financial requirements
--Provided States with the option of immediately extending coverage to all children under age 5 (and born before 10/1/83), regardless of family structure

Table III.1 (continued)

OBRA 1986

- --Provided States with the option of extending Medicaid to all pregnant women, infants, and (on a phased-in basis) children up to age 5 with incomes up to 100% of the Federal poverty level
- --Provided States with the option of extending Medicaid to elderly and disabled poor with incomes up to 100% of the Federal poverty level, provided that some or all of pregnant women, infants, and children groups are covered as well
- --Provided States with the option of paying under Medicaid only the Medicare cost-sharing obligations of elderly and disabled poor with incomes up to 100% of Federal poverty level, provided that some or all of pregnant women, infants, and children groups are covered as well
- --Provided States with the option of allowing providers to grant limited presumptive eligibility to pregnant women
- --Required States to provide emergency services to otherwise eligible aliens who fail to meet Medicaid eligibility on alienage and citizenship
- --Made permanent previously mandated Medicaid coverage for some former disabled SSI recipients who have returned to work

SOURCES: Hill (MPE Working Paper 5.2); Commerce Clearing House, Consolidated Omnibus Budget Reconciliation Act of 1985 (Report Number 489) and Omnibus Budget Reconciliation Act of 1986 (Report Number 505), Chicago, Illinois, 1986; Rymer and Burwell (MPE Working Paper 5.6).

Medicaid recipients was cut back in all States, yet at the same time States were provided with additional flexibility to expand their optional eligibility coverage.

Specifically, OBRA 1981 contained provisions which substantially reduced the number of families eligible for AFDC cash assistance. These reductions were mandatory for all States and were aimed primarily at families with earned income and at older children (19-20 year olds). OBRA 1981 also mandated uniform resource standards for AFDC cash assistance which affected all types of AFDC families. For some States, these standards represented a loosening of resource limits, but for a greater number of States they caused eligibility requirements to be more stringent. Two years later, DEFRA softened some of the OBRA cutbacks for working families. However, AFDC coverage for working families continues to be more restrictive than it was prior to OBRA 1981.

Although the coverage of AFDC cash recipients was cut back, OBRA 1981, DEFRA, COBRA, and OBRA 1986 also mandated some expansions in Medicaid coverage of families and children not receiving AFDC cash benefits (these recipients are hereafter referred to as non-cash recipients). States were required to provide extended Medicaid coverage to AFDC families who lost AFDC eligibility because of athe OBRA mandated time limit on earned income disregards. States were required to expand their Medicaid coverage of financially eligible pregnant women, regardless of their eligibility for AFDC. States were also mandated to phase in coverage of children under age 5 in low-income two-parent families (so-called Ribicoff children), if they did not already provide such coverage.

Even more significantly, States were given much greater flexibility with regard to their optional coverage of non-cash groups for Medicaid. In

particular, States were allowed to implement targeted medically needy programs, covering only pregnant women and children. Restrictions also were loosened regarding the option to fully cover Ribicoff children--generally children in two-parent families--allowing States to set the maximum age of coverage at 18, 19, 20 or 21 years, instead of 21 years as previously required. States were given the option of covering AFDC families losing cash assistance eligibility because of earnings for an additional six months of coverage beyond the mandatory period. Most recently, with OBRA (1986), States have been given the option of changing the financial criteria they use to determine Medicaid eligibility for pregnant women, infants, and children through age 5 (as well as the aged and disabled). For these groups, a special income eligibility level can be set up to 100 percent of the Federal poverty level.

Several States have responded to this increased flexibility for families and children, including many which historically have had very restricted Medicaid eligibility policies. Through 1986, some 7 States had added medically needy programs 4 of which were targeted for children and pregnant women.[1] Another 12 States had added full Ribicoff coverage for all low-income children under age 18.[2] Early indications are that over half of the States

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1. Ian Hill, Broadening Medicaid Coverage of Pregnant Women and Children: State Policy Responses, National Governors' Association, Washington, D.C., February, 1987.

2. Dana Hughes, Kay Johnson, Janet Simons, and Sara Rosenbaum, Maternal and Child Health Data Book, Children's Defense Fund, Washington, D.C., 1986.

will respond to the OBRA 1986 changes allowing use of the Federal poverty level for financial eligibility determination.[1]

Changes in Federal legislation have had only minor effects on the Medicaid eligibility of the aged, blind, and disabled over the last few years. In 1980, SSI legislation was amended to prohibit the transfer of assets in order to attain eligibility. TEFRA in 1982 provided States with the option of enacting rules which would deny Medicaid eligibility to nursing home residents who dispose of their homes for less than fair market value within two years before applying for Medicaid. More recent SSI-related legislation expanded eligibility for the aged and disabled. DEFRA in 1984 mandated the indexing of the asset levels used for SSI through 1989. (No such provision was enacted for the AFDC program.) OBRA (1986) made permanent a provision for providing Medicaid coverage to former blind and disabled SSI recipients who, though still medically disabled, are able to work. OBRA (1986) also provided States the option to use a special income level up to 100 percent of the poverty level for Medicaid eligibility determination of the aged and disabled poor, as long as they did so for pregnant women or children as well.

The most important aspect of Medicaid eligibility policy over the last ten years, however, has nothing to do with recent Federal legislation. Rather, it involves the substantial discretion States have always had over the financial criteria used to determine Medicaid eligibility for the AFDC population. Most states have failed to adjust the AFDC financial criteria used to determine eligibility for families and children to keep up with increases in the cost of living, while at the same time the income standards used for the

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1. Ian Hill (National Governors' Association), Presentation at the Annual Meeting of State Medicaid Directors, Washington, D.C., June 16, 1987.

aged, blind, and disabled have more than matched the pace of inflation. As a result, in most States, cash assistance policies over the last ten years have treated the aged and disabled more favorably than poor children and families, and this policy is reflected in Medicaid eligibility trends.

How did this happen? The key is that the Federal government plays the critical role (through the SSI program) in setting the financial standards for the aged, blind, and disabled, but States are totally responsible for setting the AFDC-related standards. By Federal law, the SSI program has always been indexed to increases in the cost of living, but only one State (California) has chosen to index its AFDC standards. Most States also supplement the Federal SSI standard. However, even if a State decides not to increase its SSI supplement, standards for the aged and disabled are raised in each State as a result of the automatic Federal increase.

Tables III.2 and III.3 document the changes in AFDC and SSI income eligibility levels among States.[1] Between 1975 and 1985, AFDC maximumu benefit levels decreased 30 percent in the median State in inflation-adjusted dollars. Many single-parent families who would have been financially eligible fifteen years ago would not qualify for AFDC or Medicaid today. Since State medically needy income levels are required by Federal legislation to be no greater than 133 percent of the AFDC benefit level, the financial criteria used in State medically needy programs have also been affected by the decline in AFDC levels.

For SSI, the pattern is reversed. The Federal SSI benefit level has increased by 10 percent in inflation-adjusted dollars from 1975 to 1986.

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1. Table III.2 shows the AFDC benefit level for each State for a 4-person family. This level is generally used as a proxy for the amount of income a family of this size can have to qualify for AFDC benefits. A similar assumption is made with the SSI benefit level in Table III.3.

Table III.2

AFDC Maximum Benefit Level for a Four-Person Family: 1975-1985

State	July 1975	January 1985	Percent Change in Constant 1985 Dollars
Idaho	$344	$344	-49%
West Virginia	249	249	-49
Kentucky	235	246	-47
Alabama	135	147	-44
Hawaii	497	546	-44
South Dakota	329	371	-42
Oregon	413	468	-42
Illinois	317	368	-41
Iowa	356	419	-40
Kansas	353	422	-39
Nevada	230	279	-38
Virginia	311	379	-38
North Carolina	200	244	-38
New Hampshire	346	429	-37
Wyoming	250	310	-37
New Jersey	356	443	-37
Massachusetts	368	463	-36
Indiana	250	316	-36
Pennsylvania	349	444	-35
Tennessee	132	168	-35
Michigan	399	512	-35
Delaware	258	336	-34
North Dakota	347	454	-33
Oklahoma	264	349	-33
District of Columbia	297	399	-31
Arkansas	140	191	-30
Utah	306	425	-29
New York	400	566	-28
Ohio	254	360	-28
Arizona	197	282	-27
Texas	140	201	-27
Louisiana	158	234	-24
Washington	370	561	-23
New Mexico	206	313	-23
Maryland	242	376	-21
Wisconsin	403	636	-20
Connecticut	403	636	-20
Minnesota	385	611	-19
Colorado	264	420	-19
Georgia	153	245	-18
Florida	170	284	-15
Vermont	367	622	-14
Nebraska	245	420	-13
Rhode Island	319	547	-13
Montana	227	425	-5
California	349	660	-4
South Carolina	117	229	0
Mississippi	60	120	2
Alaska	400	800	2
Missouri	150	308	5
Maine	219	465	8
Median State	221	379	-30
Poverty Level	420	884	

SOURCE: Committee on Ways and Means, U.S. House of Representatives, Children in Poverty, U.S. Government Printing Office, Washington, D.C., 1985 (Rymer and Burwell, MPE Working Paper 5.6).

Table III.3

SSI/SSP Benefit Levels for an Aged Individual
Living Independently: 1975-1986

State	January 1975	January 1986	Percent Change in Constant 1986 Dollars
Massachusetts	$269	$465	-17%
Nebraska	213	391	-12
Wisconsin	228	438	-8
Minnesota	189	371	-6
New York	207	408	-6
Hawaii	173	341	-6
Oregon	169	338	-4
Nevada	185	373	-3
Idaho	192	388	-3
New Jersey	182	368	-3
Connecticut	238	482	-3
New Hampshire	170	350	-1
Washington	176	364	-1
Colorado	185	394	2
Michigan	170	364	2
Rhode Island	183	392	3
Oklahoma	183	396	4
Maine	156	346	6
Pennsylvania	166	369	6
Vermont	175	392	7
California	235	533	9
Alabama	146	336	10
Arkansas	146	336	10
Delaware	146	336	10
Florida	146	336	10
Georgia	146	336	10
Indiana	146	336	10
Iowa	146	336	10
Kansas	146	336	10
Kentucky	146	336	10
Louisiana	146	336	10
Maryland	146	336	10
Mississippi	146	336	10
Missouri	146	336	10
Montana	146	336	10
New Mexico	146	336	10
North Carolina	146	336	10
North Dakota	146	336	10
Ohio	146	336	10
South Carolina	146	336	10
Tennessee	146	336	10
Texas	146	336	10
Virginia	146	336	10
West Virginia	146	336	10
Utah	146	346	13
South Dakota	146	351	13
District of Columbia	146	351	13
Alaska	250	603	16
Wyoming	146	356	17
Median State	146	346	10
Poverty Level	197	430	

SOURCE: Social Security Administration, Selected Characteristics of State Supplementation Programs: January 1975 and Characteristics of State Assistance Programs for SSI Recipients: January 1986 (Rymer and Burwell, HPE Working Paper 3.6).

State supplementation levels for SSI have not increased at the same rate. However, the effect in the median State is still that the SSI benefit level has increased by 10 percent. Thus, some aged and disabled whose income would have prevented them from qualifying ten years ago would qualify for Medicaid today.

Some States might have been willing to set higher income levels for Medicaid (only) eligibility for AFDC-related families, if Federal regulations had permitted. The problem is that States are often reluctant to update their financial criteria for AFDC because of the added burden to their cash assistance programs, not Medicaid. Whereas the Federal government assumes the entire cash assistance burden for increasing the SSI Federal benefit level, States always share in the costs of increasing AFDC levels.[1] It will be interesting to see how States respond to the OBRA 1986 provisions which give them the flexibility to set special Medicaid-only income standards up to the poverty level for targeted groups.

Thus, the most important development in Medicaid eligibility policy over the last decade has been a substantial shift in the financial criteria used to determine eligibility across the major enrollment groups. Benefit levels used for the AFDC program (and thus Medicaid) have declined substantially in inflation-adjusted terms, whereas the levels used for the aged and disabled have increased modestly, largely due to the indexing of Federal SSI benefits. In a sense, these changes were passive, rather than active policy decisions. States made AFDC eligibility policy by not raising their AFDC benefit levels, while increases in SSI levels were largely beyond the States' control.

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1. Federal participation rates for AFDC cash assistance are generally the same as for Medicaid.

Nevertheless, these financial criteria are pivotal to eligibility determination, and thus must be interpreted as important policy developments in Medicaid, regardless of how the decisions were made.

Moreover, the decline in AFDC benefit levels was exacerbated by Federal legislative changes which made eligibility for AFDC cash assistance and Medicaid more restrictive for working poor families and older children. However, at the same time, Federal law mandated States to expand their Medicaid coverage of some non-cash groups of children and families, and provided increased flexibility to States to expand their coverage of other such groups of families and children, especially Ribicoff children. In effect, eligibility for Medicaid through the AFDC cash program has been made more restrictive, while eligibility for Medicaid for some non-cash groups has been enhanced.

What Has Been the Impact of Medicaid Eligibility Policy Changes on Medicaid Enrollment? How Have Changes in Medicaid Eligibility Policy Affected Medicaid's Coverage of the Poverty Population?

The Medicaid eligibility policies discussed in the previous section have had important impacts in determining who actually gets enrolled in Medicaid. Due to the fundamental ties between Medicaid eligibility policy and eligibility for AFDC and SSI, the composition of the Medicaid recipient population underwent a significant transformation between 1975 and 1985. This transformation is not obvious. In fact, the total number of persons receiving medical assistance under Medicaid changed very little over this period. In 1975, the number of Medicaid recipients was 20.3 million, compared to 20.2 million in 1985. However, relative to the size and composition of the overall poverty population, the Medicaid recipient population changed dramatically. These changes, in turn, have had important impacts on the Medicaid program's role in

providing medical care for poor persons who lack alternative health care coverage (Rymer and Burwell, MPE Working Paper 5.6).

AFDC Enrollment. Persons in AFDC-related families comprised 70 percent of all Medicaid recipients in 1985. Of all AFDC-related families receiving Medicaid, 85 percent were eligible for Medicaid because they received AFDC payments; 15 percent did not receive AFDC cash benefits and were eligible for Medicaid only.

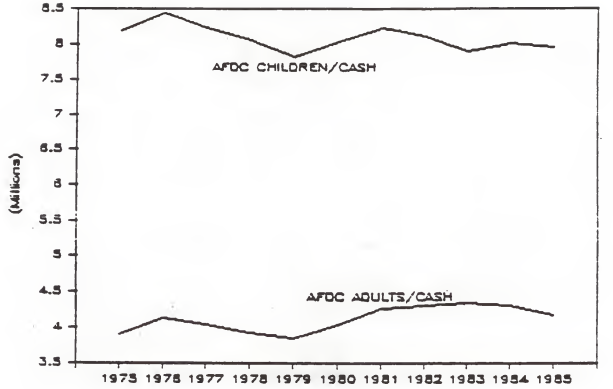
Between 1975 and 1985, the number of AFDC cash recipients on Medicaid remained virtually unchanged, at 12.1 million persons (Figure III.1), while the number of non-cash AFDC-related recipients increased. AFDC children receiving cash declined by about 3 percent, while the number of AFDC adults receiving cash increased by about 7 percent. The increasing ratio of AFDC adults to children is largely due to a decline in the average size of AFDC family units in recent years.

Although their total number is still relatively small, the number of AFDC non-cash recipients has increased substantially, particularly since 1979, as shown in Figure III-2. Between 1979 and 1985, the number of AFDC adults on Medicaid who were not receiving cash doubled, from 432,000 to 865,000. Over the same period, the number of AFDC-related children receiving Medicaid but not AFDC cash benefits increased 43 percent, from 871,000 to 1,244,000. Thus, it appears that the Federal legislative changes enacted during the early 1980s have had a definite impact on expanding Medicaid eligibility to AFDC-related families not receiving cash assistance.

The meaning of this expansion becomes clearer, however, when discussed in the context of overall poverty trends. One measure of the Medicaid program's success in fulfilling its objectives is the degree to which the program

Figure III.1

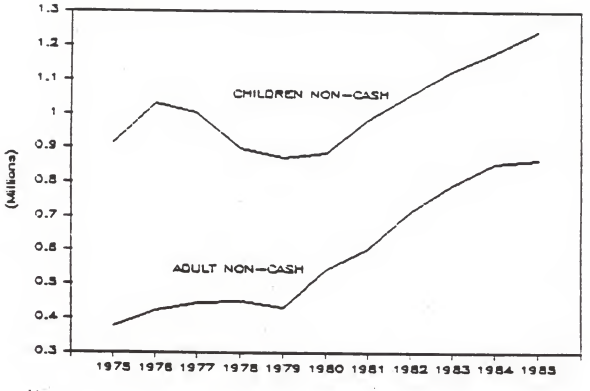
AFDC Cash Recipients Receiving Medicaid
1975-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy (Rymer and Burwell, MPE Working Paper 5.6).

Figure III.2

AFDC-Related Non-Cash Recipients Receiving Medicaid
1975-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy (Rymer and Burwell, MPE Working Paper 5.6).

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responds to national trends in the number of persons living in poverty who have little or no health care coverage. In this context, enrollment trends look rather different.

As shown in Figure III.3, Medicaid's role in providing health care coverage for poor children has eroded considerably. In 1978, there were about 984 children receiving medical assistance through Medicaid for every 1,000 children in poverty. By 1983, that ratio had declined to 737 children receiving Medicaid for every 1,000 children in poverty, a 25 percent drop in coverage. As Figure III.3 illustrates, although the number of children receiving Medicaid increased moderately between 1978 and 1983, the increase fell far behind the rise in overall poverty among children. By 1985, the ratio had again risen to 813 children on Medicaid per 1,000 children in poverty, due to a decline in the number of children in poverty between 1983 and 1985.[1]

The erosion in Medicaid coverage of poor children is due primarily to two factors. First, the decline in AFDC payment levels has reduced the number of AFDC-related families eligible for Medicaid. As previously discussed, AFDC payment levels declined in real terms by an average of 30 percent between 1975 and 1985. As a result, a declining percentage of children in poverty were in families which received AFDC payments, and therefore a declining proportion of

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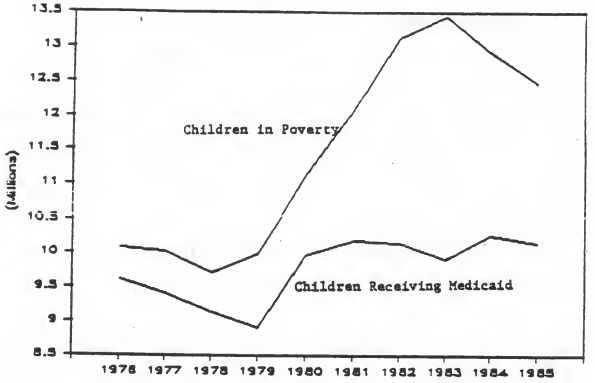
1. These data are not consistent with other data drawn from the March Current Population Survey (CPS) which indicate that the percentage of poor children covered by Medicaid has been relatively constant over time. (See Chapter IV). Part of athe discrepancy relates to the fact that HCFA program data include children on Medicaid with incomes above the poverty level. Interpretation of CPS data suggests that the decline in Medicaid's coverage of children has occurred primarily among children living above poverty. However, changes in the methodology by which the CPS has measured Medicaid coverage among children may also partly explain the discrepancy.

Figure III.3

Number of Children in Poverty and Number of
Children Receiving Medicaid
1976-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy; Social Security Administration, Office of Research and Statistics; and U.S. Bureau of the Census. Number of children receiving Medicaid underestimates Medicaid coverage of children in poverty since it does not include children who were enrolled but received no Medicaid-funded services. Children receiving Medicaid includes all persons reported as "others" (primarily Ribicoff children) beginning with 1980. Number of children receiving Medicaid prior to 1980 are therefore undercounted here. Number of children receiving Medicaid also includes adjustments for number of SSI disabled children receiving Medicaid. (Rymer and Burwell, MPE Working Paper 5.6).

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children in poverty were eligible for Medicaid. While Medicaid eligibility changes did permit expanded coverage of some groups of children above the AFDC income cutoff, the increase in these non-cash child recipients of Medicaid was relatively minor compared to the much larger cutbacks in the AFDC cash assistance program.

The second reason for Medicaid's eroding coverage of poor children is the fact that an increasing proportion of children in poverty are in two-parent families, a group which has traditionally been eligible for Medicaid only at State option (Ribicoff children). In fact, from 1978 to 1983 the number of poor children increased by 3.6 million, and of these, 2.6 million (79 percent) were in male-present families.[1] By 1983, children in male-present families comprised almost half (49 percent) of all poor children. Thus, Medicaid's financial and categorical ties to the AFDC program have both contributed to its declining coverage of poor children in recent years.

Many of the Federal and State Medicaid eligibility changes in recent years have focused on expanding Medicaid's coverage of children in two-parent families. The number of States offering coverage to all Ribicoff children under age 18 has grown from less than 20 States in 1983, to 32 States in 1986.[2] At the same time, Congress has mandated all States not offering full Ribicoff coverage to phase in at least some coverage for this group. Under DEFRA 1984, States were required to extend Medicaid eligibility to all

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1. Children in Poverty, Committee on Ways and Means, U.S. House of Representatives, 1985.

2. Dana Hughes, Kay Johnson, Janet Simons, and Sara Rosenbaum, Maternal and Child Health Data Book, Children's Defense Fund, Washington, D.C., 1986.

Ribicoff children born after September 30, 1983, up to the age of five. Thus, all States now cover some children in two-parent families.

Unfortunately, these expansions in Medicaid's eligibility provisions have had limited success in reaching low-income children in two-parent families. For the children to be eligible for Medicaid, these two-parent families are still required to meet AFDC (or medically needy) financial criteria. Almost three-fourths of two-parent families living in poverty had annual incomes between $5,000 and $10,000 in 1984. Since the median medically needy income cutoff for a family of four in 1984 was $5,496, the vast majority of poor two-parent families do not meet Medicaid's financial eligibility requirements unless they incur catastrophic health care expenses which cause them to spend down to Medicaid medically needy levels. Thus, although Medicaid eligibility changes have broadened the base of potentially eligible children, low AFDC and medically needy income cutoffs greatly limit the number of children in two-parent families who qualify financially.

Consequently, it is not surprising that only about 2.2 million of the 6.2 million poor children (35 percent) in two-parent families were enrolled in Medicaid in 1985, either under the Ribicoff children or AFDC-U coverage options.

Of significance, OBRA (1986) represents the first time that States have been allowed to sever the financial, as well as categorical, ties between the AFDC program and Medicaid. As previously discussed, States may provide Medicaid coverage to pregnant women and children (up to age five, on a phased-in basis) in families with incomes up to the Federal poverty level. The OBRA 1986 changes will therefore serve as a major test of whether States are

willing to reverse Medicaid's declining coverage of poor women and children by raising their financial eligibility levels for Medicaid only.

SSI Enrollment. Like the AFDC population, the total number of aged and disabled persons receiving Medicaid was virtually the same in 1985 as in 1975. There were 5,911,000 aged and disabled Medicaid recipients in 1975, and 5,927,000 in 1985, an increase of only 0.3 percent. According to State Medicaid reports (HCFA 2082 data), the number of elderly persons on Medicaid has declined considerably, while the number of disabled Medicaid recipients has steadily increased. However, these State reports are misleading because a growing proportion of disabled Medicaid recipients are, in fact, over age 65. In most cases, persons who originally qualify for SSI cash assistance (and Medicaid) prior to age 65 continue to be classified as disabled after passing their 65th birthday. In 1985, about 22 percent of all disabled Medicaid recipients receiving SSI cash assistance, some 495,000 persons, were age 65 or over. Thus, while there has been a slight decline in the number of elderly persons receiving Medicaid, the decline is far less than HCFA 2082 data on the aged suggest.

It is true that the number of aged Medicaid recipients receiving SSI cash assistance has declined, even after adjusting for disabled persons over 65, as shown in Figure III.4. This decline reflects enrollment trends in the SSI program itself; the number of elderly persons qualifying for SSI cash payments dropped by over 15 percent between 1976 and 1985.[1]

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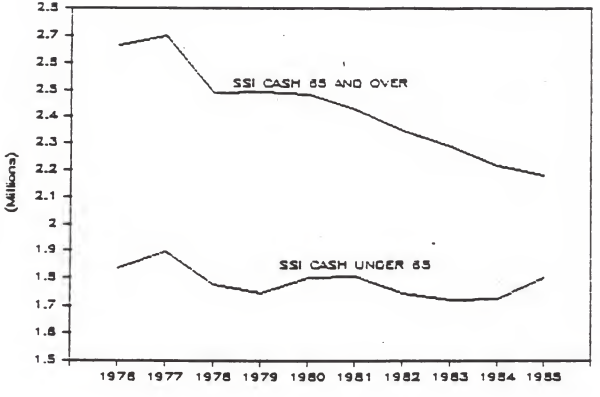
1. The number of SSI recipients reported by the Social Security Administration and the number of Medicaid recipients who also receive SSI reported by States are not equal because: (1) not all States provide Medicaid coverage for all SSI recipients; (2) some SSI recipients do not use services covered by Medicaid (i.e., they are enrollees, but not recipients); and (3) States report the total number of Medicaid recipients in a fiscal year, while SSA reports SSI recipients on a monthly basis.

Figure III.4

SSI Cash Recipients Receiving Medicaid
1975-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy; and Social Security Administration, Office of Research, Statistics and International Policy. Data include adjustments for disabled Medicaid recipients age 65 and over. (Rymer and Burwell, MPE Working Paper 5.6).

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The decline in the number of elderly persons qualifying for SSI assistance is primarily attributable to the overall decline in poverty among the elderly. Between 1976 and 1985, the poverty rate among persons 65 years of age and over dropped from 15.0 percent to 12.6 percent. Over the same time period, the percentage of elderly persons qualifying for Federally administered SSI/SSP payments dropped from 10.3 percent to 7.3 percent.[1]

However, the decline in the number of elderly persons qualifying for SSI may be reversing. Since 1982, the overall growth in the elderly population has begun to outpace the decline in the poverty rate, particularly among persons over the age of 75. As a result, the number of elderly SSI recipients has ceased to decline, as shown in Figure III.5. Unless the poverty rate for aged persons continues to fall, the number of aged SSI recipients will again increase, which will in turn increase the size of the aged Medicaid population in the coming years.

As with the AFDC population, the number of aged and disabled Medicaid recipients not receiving SSI cash has grown substantially (Figure III.6). The number of disabled non-cash recipients grew by 30 percent between 1975 and 1985, and aged non-cash recipients grew by 20 percent. The growth of the aged non-cash population is primarily attributable to the growth in the number of aged Medicaid recipients in nursing homes. Since nursing home recipients are only eligible for SSI cash payments if their incomes fall below the personal needs allowance (generally $25 per month), only about 14 percent of the Medicaid nursing home population receive SSI cash. Thus, growth in the Medicaid nursing home population will automatically increase the non-cash population.

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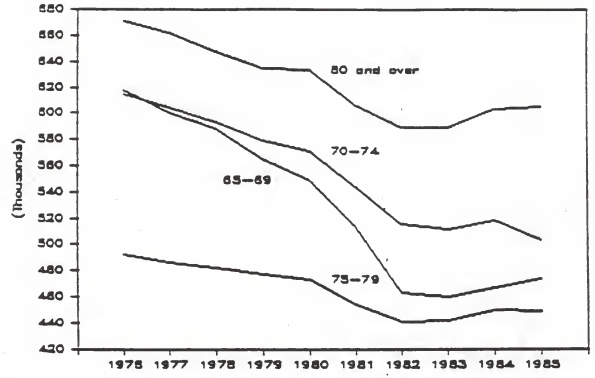
1. Excludes a small number of elderly persons who receive State-administered supplementation payments only.

Figure III.5

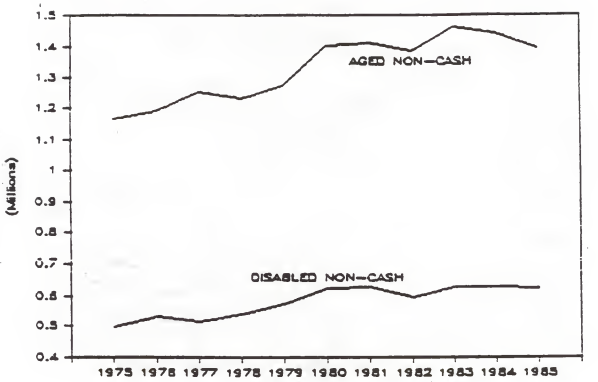
Number of Aged SSI Recipients, by Age Group
1976-1985



SOURCE: Social Security Administration, Office of Research and Statistics. Data include adjustments for disabled SSI recipients age 65 years of age and over. (Rymer and Burwell, MPE Working Paper 5.6).

Figure III.6

SSI-Related Recipients Not Receiving Cash
1975-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy. Disabled non-cash recipients over age 65 are reported as disabled. (Rymer and Burwell, MPE Working Paper 5.6).

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In fact, 80 percent of the increase in the aged non-cash population between 1976 and 1985 is attributable to growth in the long-term care population. It is not possible to ascertain from available data sources what proportion of these elderly nursing home recipients would have been eligible for SSI cash assistance if they had not been institutionalized.

Reasons for the growth of the disabled non-cash population are more difficult to ascertain. It is not primarily due to increases in the number of disabled Medicaid recipients in nursing homes, which accounts for only about 25 percent of the total increase. It is also not attributable to recent legislation (Section 1619 of the Social Security Disability Amendments of 1984), which has attempted to remove some of the disincentives for disabled SSI recipients to return to work, since there were only about 8,770 persons receiving Medicaid under the Section 1619 program in 1985.[1]

Assessing Medicaid's coverage of the elderly poor is confounded by the fact that 38 percent of aged Medicaid recipients are nursing home users, and elderly persons in nursing homes and other group quarters are not counted in official poverty statistics. Consequently, Figure III.7 shows trends in the number of non-institutionalized elderly persons on Medicaid relative to the number of elderly in poverty. In contrast to the erosion in Medicaid coverage of poor children, there has been no similar erosion in coverage for the elderly poor since 1980. The decline in the number of non-institutionalized elderly receiving Medicaid is reflected by a decline in the number of elderly in poverty.

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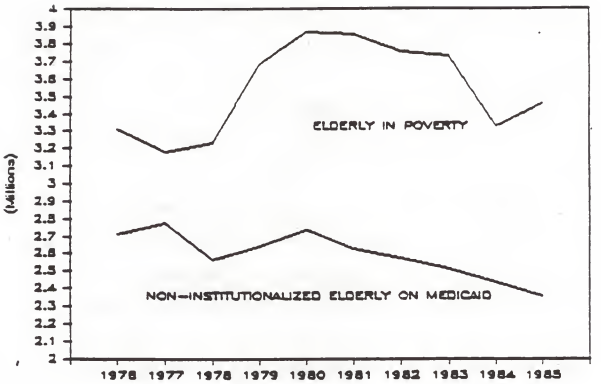
1. Social Security Administration, Office of Programs and Policy, Office of Supplemental Security Income, Report to the Congress: Implementation and Analysis of Public Law 98-460--Section 1619 (The Social Security Disability Benefits Reform Act of 1984).

Figure III.7

Medicaid Coverage of the Non-Institutionalized Elderly
1976-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy; and U.S. Bureau of the Census. Medicaid data include adjustments for disabled Medicaid recipients over age 65.

Nevertheless, Medicaid's coverage of the non-institutionalized elderly was still below Medicaid's coverage of poor children in 1985. There were about 681 non-institutionalized elderly on Medicaid per 1,000 elderly in poverty in 1985 compared to 813 children on Medicaid per 1,000 children in poverty. This is surprising, given that the Federal SSI benefit level alone, not including State supplements to SSI, was 78 percent of the poverty threshold in 1985, while the AFDC benefit level in the median State was only 43 percent of the poverty threshold.

However, SSI/SSP recipients must not only meet income eligibility criteria, but asset criteria as well. Poverty measures, on the other hand, are based solely on income, and do not take into account available assets. In 1985, the Federal SSI limit on countable assets (primarily liquid assets) was $1,600 for an individual and $2,400 for couples. Thus, many elderly persons may meet SSI/SSP income criteria, but have excess assets. Second, there is evidence that many elderly persons who could potentially qualify for SSI/SSP benefits do not participate in the program, particularly couples and individuals whose incomes fall just below SSI/SSP income levels.[1] These persons may be unaware that although they would be eligible for only a small SSI/SSP benefit, their eligibility for SSI/SSP would also entitle them to Medicaid, the benefits of which could be substantial.

National data on Medicaid's coverage of the elderly poor also mask important differences across States. Since States are free to set their State

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1. Urban Systems Research and Engineering, A Pilot Study of Eligibility and Participation in the Supplemental Security Income Program, Social Security Administration, Office of Research and Statistics, Contract No. HHS-600-77-0125, 1981.

Supplementation Payments (SSP) at whatever level they choose, some elderly persons with incomes above the poverty level can qualify for Medicaid, while elderly persons in other States with incomes substantially below the poverty line do not qualify. For example, in 1984, there were about 206,000 elderly persons living below the poverty line in California. Due to California's generous SSI/SSP payment level, there were about 579,000 elderly Medicaid recipients in California, a ratio of 2.8 to 1. At the other extreme, there were 256,000 elderly persons living below the poverty line in Florida in 1984, but only 136,000 elderly persons received Medicaid, a ratio of 0.53 to 1.

Excluding aged Medicaid recipients who were nursing home users underestimates Medicaid's coverage of the elderly poor. Many nursing home recipients are relatively short-stayers who are discharged after recovery from an acute illness episode. Many others enter nursing homes with a terminal illness. Thus, a substantial proportion of aged Medicaid recipients are both non-institutionalized and institutionalized recipients during a particular year. If one includes the Medicaid nursing home population in assessing Medicaid's coverage of the elderly, there were more elderly persons receiving medical assistance from Medicaid in 1985 (3,559,000) than there were elderly persons living in poverty (3,456,000). While the number of non-institutionalized elderly on Medicaid is declining, the number of institutionalized elderly on Medicaid is increasing. The ratio of total aged Medicaid recipients to elderly persons in poverty remained constant, at about 1:1, over the decade.

Since there are no data on the number of disabled persons living below the poverty line, it is difficult to assess Medicaid enrollment trends for the disabled relative to the total number of disabled poor.

What Impact Have Medicaid Eligibility Changes Had on Expenditures?

The Medicaid enrollment trends discussed above had had important impacts on Medicaid expenditures. Although poor families and children make up a growing proportion of the poverty population, the proportion of Medicaid resources directed to poor families and children is declining. As shown in Figure III.8, in 1975, 35 percent of Medicaid expenditures were for medical services provided to AFDC-related families. Ten years later, AFDC-related recipients accounted for only 24 percent of Medicaid costs.

This redistribution in expenditures is due to the higher costs of serving the aged and disabled (Figure III.9). Over the 1975-1985 period the average costs per aged and disabled recipient increased at annual compound rates of growth of 4.7 percent and 4.0 percent, respectively, in inflation-adjusted dollars.[1,2] Increases were more moderate between 1980 and 1985 than between 1975 and 1980. For AFDC-related children and adults, average costs per recipient actually declined slightly over this ten-year period. Declines were sharper between 1980 and 1985 than between 1975 and 1980.

Why have average costs for aged and disabled Medicaid recipients outpaced overall price increases in health care? The reasons differ for the two groups. For the aged, part of the increase is attributable to a shift in the mix of services utilized--an increasing proportion of aged Medicaid recipients are long-term care users. While the total number of elderly persons receiving

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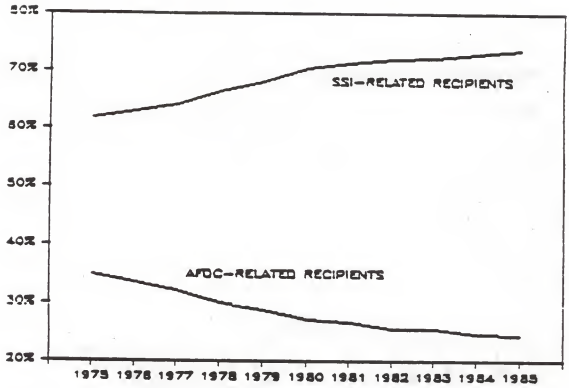
1. For the analyses presented in this section, disabled recipients age 65 and over are counted in the disabled group, since national data on Medicaid expenditures for the disabled who are also elderly are not available.

2. All adjustments for inflation presented in this section are based on the medical care component of the CPI.

Figure III.8

Distribution of Medicaid Expenditures, by Eligibility Group
1975-1985

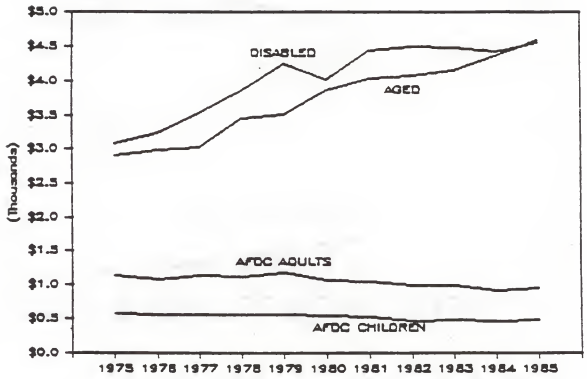


SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy.

Figure III.9

Average Annual Cost per Medicaid Recipient, by Eligibility Group
1975-1985

(in 1985 dollars)



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy. Expenditures for disabled recipients age 65 and over are included in disabled group. (Rymer and Burwell, MPE Working Paper 5.6).

Medicaid declined slightly, the number of aged long-term care users increased from 1.0 million to 1.2 million. The proportion of aged Medicaid beneficiaries who were recipients of long-term care services increased from 29.5 percent to 39.4 percent over the ten-year period. This change in the mix of services used by the aged Medicaid population contributed to increases in the average cost per aged beneficiary.

However, it was not the primary factor. In fact, while an increasing proportion of aged recipients were long-term care users, long-term care expenditures represented a declining proportion of total expenditures for the aged over this period (Figure III.10). The more important trend has been increased costs for services other than long-term care. Between 1975 and 1985, the average cost for non-institutional services (all services excluding long-term care) per aged Medicaid beneficiary increased from $546 to $1,216 in 1985 dollars, an increase in real terms of 123 percent.[1]

Thus, the increased costs to Medicaid of serving aged beneficiaries is not simply due to the fact that Medicaid provides coverage of nursing home care while Medicare does not. Since Medicaid expenditures for the aged (other than long-term care) mainly represent costs not covered by Medicare (coinsurance, deductibles, extended hospital stays, home health visits which do meet Medicare criteria, prescription drugs, etc.), this increase in non-institutional costs for aged recipients represents a growing burden on State

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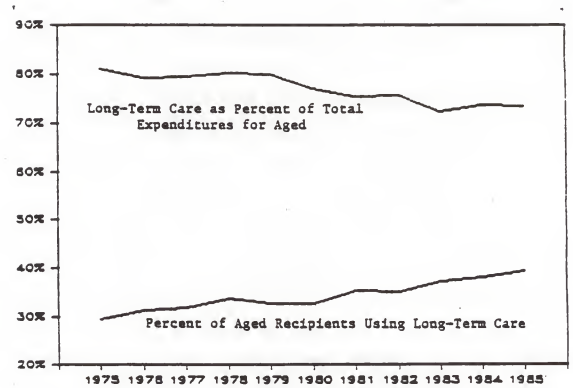
1. These increases do not include State Medicaid program "buy in" costs for dual enrollees, only increases in payments to providers. Also, since long-term care recipients also incur costs for other Medicaid services (e.g., hospital care, physician services, etc.), it is not possible to ascertain with national Medicaid data to what extent increased costs for non-institutional services are attributable to long-term care recipients and to what extent they are attributable to aged recipients who are not long-term care users.

Figure III.10

Proportion of Total Aged Medicaid Recipients Using Long-Term Care Services and Long-Term Care Expenditures as Proportion of Total Expenditures for the Aged
1975-1985



SOURCE: HCFA 2082 data, Bureau of Data Management and Strategy. (Rymer and Burwell, MPE Working Paper 5.6).

Medicaid programs for costs not covered by Medicare.[1] Further analyses are needed to determine the factors which underlie costs increases for aged recipients who are not users of long-term care, and to describe more fully the fiscal relationships between Medicaid and Medicare for this dually enrolled population.

For the disabled, it is the increased cost per institutionalized recipient which is driving cost increases. While the percentage of disabled recipients in long-term care facilities did not increase, the average cost per disabled recipient in long-term care almost doubled in inflation-adjusted terms over this period, from $9,000 in 1975 to almost $18,000 in 1985. The primary factor for this increase was the implementation of the ICF-MR program during the late 1970s. ICF-MR recipients account for only about one-third of all disabled recipients in long-term care, but for about 70 percent of long-term care expenditures for the disabled. Between 1975 and 1985, ICF-MR expenditures increased on an inflation-adjusted basis from $908 million to over $4.7 billion, and the average annual cost per recipient of ICF-MR care increased from $13,000 to $33,000 (Rymer and Burwell, MPE Working Paper 5.6).

* * *

In conclusion, although the original objective of Medicaid was to provide health insurance protection for the poor who lack alternative health care coverage, recent trends in Medicaid eligibility have counteracted this objective. Between 1975 and 1985, poverty rates for the elderly declined, while

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1. This does not necessarily mean that Medicaid is picking up a larger proportion of the total health care costs for dually enrolled aged beneficiaries, since Medicare costs for the dually enrolled may be rising at an equal, or higher rate.

the incidence of poverty among families and children increased substantially. Medicaid has not responded to this shift in the poverty population. A declining proportion of poor children and families receive medical assistance through Medicaid, while Medicaid's coverage of the elderly poor has been maintained. Due to the higher medical costs of serving aged and disabled recipients, an increasing proportion of Medicaid resources are consumed by aged and disabled recipients. Medicaid's role in providing access to health care services for the vast majority of persons living in poverty, particularly children, has eroded substantially, due to the fundamental ties between Medicaid eligibility and receipt of AFDC cash benefits.

Summary

Many of the legislative changes made to Medicaid eligibility policy since 1980 were intended to provide States with the flexibility to extend Medicaid coverage to persons who are not on welfare, but who lack adequate health care coverage. However, national data on Medicaid enrollment and expenditure trends indicate that these changes, to date, have had only minor impacts on improving access to Medicaid coverage for persons in poverty. The financial criteria for AFDC and SSI cash assistance remain the primary factors driving Medicaid program enrollment.

In 1985, there were 20.2 million Medicaid recipients, compared to 20.3 million recipients ten years earlier. Over this ten-year period, there was a significant shift in the composition of the overall poverty population resulting from an increased incidence of poverty among families and children, and a decline in poverty among the elderly. Medicaid enrollment trends did not reflect this shift in the poverty population, especially for children and families.

Inflation-adjusted declines in AFDC benefit levels between 1975 and 1985 have had a major impact on limiting Medicaid enrollment of poor children and families. Because States retain wide discretion over AFDC benefit levels, and because the majority of children and families become eligible for Medicaid on the basis of their receipt of AFDC cash payments, Federal efforts to expand Medicaid coverage of non-AFDC families and children have only slightly moderated the impact of declining AFDC benefit levels.

OBRA (1986) marks the first time that States are allowed to separate Medicaid eligibility for pregnant women and young children from the AFDC or medically needy financial criteria. OBRA (1986) is thus a major test to determine whether or not States will choose to expand Medicaid enrollment for pregnant women and children with incomes between the AFDC (or medically needy) level and the poverty threshold.

In contrast to AFDC benefit levels, increases in Federal SSI benefit levels exceeded the rate of inflation between 1975 and 1985. Consequently, Medicaid's coverage of the elderly poor has not eroded over time. However, the extent of Medicaid's coverage of the elderly poor is confounded by the fact that taimost 40 percent of all aged Medicaid beneficiaries are users of nursing home care, and nursing home recipients are not included in poverty statistics. Many poor elderly persons who are not in nursing homes still do not have access to Medicaid coverage, particularly in States that do not supplement Federal SSI benefits.

Medicaid expenditures are being driven by the costs of serving aged and disabled beneficiaries. Average costs per aged and disabled recipient have risen between 4 and 5 percent annually in inflation-adjusted terms, while

costs per AFDC-related recipient have been slightly below the increase in the medical care price index.

Somewhat unexpectedly, rising nursing home costs are not the major reason why costs for aged recipients have increased so dramatically. Rather, costs for services other than long-term care have risen at a higher rate for the Medicaid aged. More research on this issue is needed, since it raises questions about the cross-program impacts of Medicare and Medicaid, and the role of Medicaid as a catastrophic insurance program for the elderly poor.

Between 1975 and 1985, Medicaid has also become the primary Federal financing source for services to persons with mental retardation and other developmental disabilities, primarily due to the addition of the ICF-MR benefit in 1972.

As a result, the proportion of total Medicaid expenditures spent on aged and disabled recipients keeps increasing. Between 1975 and 1985, the proportion of total Medicaid spending attributable to SSI-related recipients increased from 62 percent to 74 percent. AFDC-related recipients accounted for about one-third of total spending in 1975, but less than one-fourth in 1985.

IV. THE IMPACT OF 1981 OBRA LEGISLATION ON MEDICAID ENROLLMENT

The previous chapter discussed the effect that the 1981 Omnibus Budget Reconciliation Act and other subsequent legislation have had on Medicaid eligibility. That chapter also examined longer-term trends (1975 to 1985) in Medicaid eligibility for each of several groups. In this chapter, we examine more closely the period immediately before and immediately after the 1981 OBRA legislation which, of all the recent legislative initiatives, had perhaps the strongest provisions affecting Medicaid eligibility.

Data and Methodology

We summarize several studies which used different data bases. Monthly Medicaid program data on Medicaid eligibility from October 1980 through September 1982 for 31 States were used to examine the immediate impacts of OBRA and to disentangle the impacts of OBRA and the recession.[1] The Current Population Survey (CPS) was used to analyze how the noninstitutionalized Medicaid population changed in terms of age, income, and geographic region. Finally, the CPS and the National Medical Care Utilization and Expenditure Survey were used to analyze the effects of lost eligibility on health

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This chapter summarizes findings in J. Cohen and J. Holahan, "Medicaid Eligibility After the Omnibus Budget Reconciliation Act of 1981," MPE Working Paper 5.1; S. Long and R. Settle, "The Impact of Eligibility Changes Under the Omnibus Budget Reconciliation Act of 1981 on the Characteristics of the Medicaid Population," MPE Working Paper 5.3; S. Long and R. Settle, "Cutbacks in Medicaid Eligibility Under the OBRA of 1981: Implications for Access to Health Care Among the Newly Ineligible," MPE Working Paper 5.4; and K. Swartz, "Changes in the Characteristics of the Non-Institutionalized Medicaid Population," MPE Working Paper 5.5.

1. These States were selected after a careful examination of the data to assure intraperiod validity over the time period of interest.

insurance coverage and health service utilization. The major estimation technique used was multivariate analysis, to enable us to disentangle the independent effects of various factors.

How Much Did OBRA's Provisions Reduce Medicaid Enrollment?

The average number of Medicaid enrollees per month declined in 28 of the 31 States in the analysis. Between 1981 and 1982 there was an overall reduction of 4.7 percent in total enrollment. For eligibles receiving cash assistance, the reduction was somewhat more (5.2 percent); for eligibles not receiving cash assistance, the reduction was less (1.4 percent).

The reductions were unevenly distributed among the various eligibility groups in these two categories. For those receiving cash assistance, the reductions were as follows: aged, 5.9 percent; blind and disabled, 0.9 percent; AFDC children, 7.3 percent; and AFDC adults, 3.2 percent. For those not receiving cash assistance the analogous reductions were: the aged, 2.3 percent; the blind and disabled, 5.3 percent; AFDC children, 2.5 percent. In contrast to other groups, AFDC adults receiving Medicaid but not cash assistance actually increased by 9.2 percent.

These estimates do not answer the question of the impact of OBRA because factors other than OBRA—most importantly the recession--also affected the number of persons eligible.

Two studies not conducted as part of this project have estimated the OBRA effect on Medicaid enrollment, controlling for the effects of the recession. Cromwell, using a simulation model in which effects were assumed to start occurring after a 3-month lag, found that the effect attributable to OBRA for the year 1981-1982 was a reduction in enrollment of 13.4 percent (2.3 million

persons).[1] The effect attributable to the recession was a partially offsetting increase of 5.6 percent. When a whole set of factors identified by Cromwell (including, for example, the effect of population increases) are put together, his calculations amount to a net reduction in enrollment for 1981-1982 of 5.4 percent. This is relatively close to the 4.7 percent estimated by Cohen and Holahan (MPE Working Paper 5.1).

The most drastic effect was on AFDC-cash enrollees (an OBRA-induced reduction of 18 percent for 1981-1982); the effect on SSI-cash enrollees, in contrast, was minimal; the effects on the non-cash groups were between these two extremes. A General Accounting Office study (1984), which also controlled for unemployment, found a similar effect for AFDC eligibles—a reduction of almost 14 percent (including the AFDC non-cash groups).[2]

How Much Did OBRA's Effect on Enrollment Change Medicaid Expenditures?

The effect of enrollment changes on State Medicaid expenditures is a difficult issue for two reasons. First, individuals losing eligibility under Medicaid are likely to use fewer services, on average, than people remaining on the rolls. To begin with, Medicaid eligibles losing eligibility are largely from the AFDC population, which is the group with the lowest Medicaid utilization. In addition, those losing eligibility are the working poor. These individuals are likely to be healthier; they also are likely to find it harder to find the time to seek services than the non-working poor on

1. Jerry Cromwell et al., "The Evolution of State Medicaid Programs," Center for Health Economics Research, June 1984.

2. General Accounting Office, "An Evaluation of the 1981 AFDC Changes: Initial Analysis," Washington, D.C., April 2, 1984.

Medicaid. Unless these use differences are taken into account, analysis will overestimate the Medicaid saving yielded by dropping them from the rolls. The second reason why the issue is difficult is that the working poor who lost eligibility are more likely to have had private insurance (see below). It is therefore possible that States had been collecting from other third-party payers for some of the expenses borne or incurred by those individuals when they had Medicaid coverage. This again will lead to an overestimate of the Medicaid savings attributable to OBRA eligibility changes.

There are no data from which to estimate the effect of the private insurance factor. However, Long and Settle estimated utilization equations based on the NMCUES data; they then used data from the Current Population Survey on characteristics of individuals on and off of Medicaid to simulate the impact of Medicaid enrollment. This approach permitted them to recognize that the people dropped from Medicaid rolls were somewhat healthier than enrollees who remained and consequently used fewer of most health services (MPE Working Paper 5.4). They estimated that adults exiting the Medicaid rolls as a result of OBRA would have had 98.1 percent of average inpatient hospital service use, 93.4 percent of average physician service use, 93.6 percent of average drug purchases, and 103.4 percent of average dental service use. Corresponding numbers for AFDC children were 89.9 percent for inpatient hospital services, 97.7 percent for physician services, 97.9 percent for prescription drugs, and 109.3 percent for dental services. These estimates of Medicaid service use imply that dropping these people from the Medicaid rolls produced 1982 cost savings of $926.4 million.

How Has the Number of Medicaid Enrollees Changed in Different Age Groups, Income Brackets, and Geographic Regions?

The number of Medicaid recipients increased by 210,000 persons (1 percent) between 1979 and 1983. Changes in the number of Medicaid recipients, both in absolute terms and as a share of the underlying population, reflect two broad offsetting factors. The first factor was the growth in the poverty population which reflects reduced employment and income during the economic recession in 1981 and 1982. The second factor was the set of Medicaid eligibility cutbacks initiated by OBRA and the tight State controls on payment standards (which has the result of moving the working poor who receive real wage increases off the AFDC eligibility rolls). These cutbacks from both Federal and State policies reduced the likelihood that Medicaid programs would cover individuals in poverty.

An analysis of the noninstitutionalized Medicaid population by Swartz (MPE Working Paper 5.5) using Current Population Survey (CPS) data demonstrates that these offsetting effects yielded different overall effects for different eligibility groups. The number of children enrollees increased by almost 200,000 (3.7 percent) between 1979 and 1983 (see Table IV.1).[1] Young

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1. The CPS has a sample size of approximately 160,000 individuals, so each of the numbers reported here and in the following tables are statistically significant numbers. The question of whether or not the age, income, and geographic distributions are significantly different in 1979 and 1983 can be answered by computing the X^2 value for each of the three distributions. The null hypothesis is that the two years' samples are not different. For each of the three characteristics (age, income, and geographic region), the value of X^2 is significant beyond the .001 level. Therefore, we can reject the null hypothesis of no differences.

Another way of thinking about this is to ask if the proportion of Medicaid recipients with incomes below half of the poverty level (or just below the poverty level) is meaningfully different in the two years. What is "meaningfully different" is, of course, subject to interpretation; but the t-statistic relevant for this question is approximately 15, which indicates that the chances that two years' proportions are not meaningfully different is very close to zero.

Table IV.1

Number and Distribution of the Noninstitutionalized Medicaid Population by Age, Family Income Relative to the Poverty Level, and Region, 1979-1983
(Numbers in Thousands)

	1979		1983		Percent Change
	Number	Percent	Number	Percent	1979-1983
Age					
17 or younger	7,933	41.5	8,229	42.6	3.7
18-24	2,381	12.5	2,180	11.3	-9.2
25-34	2,235	11.2	2,592	13.4	16.0
35-44	1,197	6.5	1,438	7.5	20.1
45-54	977	5.3	919	4.8	-9.4
55-64	1,026	5.5	1,066	5.5	3.9
65-74	1,973	10.8	1,561	8.1	-20.9
75 or older	1,376	7.4	1,321	6.8	-4.0
Total	19,098	100.0	19,307	100.0	1.1
Family Income Relative To Poverty Level					
Below 50%	3,819	20.0	6,442	33.4	68.7
50-99%	7,153	37.5	7,653	39.6	7.0
100-124%	2,149	11.3	1,658	8.6	-22.8
125-149%	1,418	7.4	916	4.7	-35.4
150-199%	1,558	8.2	1,054	5.5	-32.3
200-299%	1,660	8.7	938	4.9	-43.5
300% or above	1,338	7.0	646	3.3	-51.7
Total	19,098	100.0	19,307	100.0	1.1
U.S. Census Divisions					
New England	1,002	5.2	914	4.7	-8.8
Middle Atlantic	3,742	19.6	3,819	19.8	2.1
East North Central	3,591	18.8	3,878	20.1	8.0
West North Central	1,092	5.7	1,090	5.7	-0.0
South Atlantic	2,658	13.9	2,360	12.2	-11.2
East South Central	1,409	7.4	1,441	7.5	2.3
West South Central	1,821	9.5	1,669	8.7	-8.3
Mountain	442	2.3	532	2.8	20.4
Pacific	3,340	17.5	3,605	18.7	7.9
Total	19,098	100.0	19,307	100.0	1.1

SOURCE: March Current Population Surveys of 1980 and 1984. Medicaid recipiency is for the previous calendar year. (Swartz, MPE Working Paper 5.5)

adults between the ages of 25 and 34 on Medicaid increased by 16 percent, and individuals between the ages of 35 and 44 by 20.1 percent. The number of aged Medicaid enrollees declined, by 21 percent for those between 65 and 74 and by 4 percent for those 75 and older.

In the previous chapter, Rymer and Burwell compared changes in all Medicaid recipients to persons in poverty. Use of the CPS permitted Swartz to compare changes in the Medicaid coverage of persons below poverty as well as those above. Swartz's analysis showed that most of the growth in the Medicaid population occurred among individuals whose family incomes were well below the poverty line. The most rapid growth (68.7 percent) occurred among individuals whose incomes were less than half the poverty line. More modest but still positive growth occurred for individuals between half the poverty line and the poverty line. Most importantly, the number of Medicaid recipients in each category above the poverty line declined, reflecting the OBRA objective of reducing Medicaid enrollment of the working poor and near-poor.

Finally, there were substantial regional differences in the growth of the Medicaid population. The number of Medicaid recipients declined in the New England, South Atlantic, and West South Central regions. In contrast, the number of Medicaid recipients increased significantly in the East North Central, Mountain, and Pacific regions.

How Have the Numbers of Medicaid Recipients Changed as a Share of the Population?

Overall, the ratio of Medicaid enrollees to U.S. population was 8.6 percent in 1979 and fell only slightly in 1983 (Table IV.2). However, the Swartz analysis makes it clear that the small reduction masks major changes that occurred among the population and among regions. Coverage of children

Table IV.2

Noninstitutionalized Medicaid Population
As a Proportion of U.S. Population,
By Age Cohort, Family Income Relative to Poverty,
and by Region of the U.S., 1979-1983

	1979	1983
Total	8.6	8.3
Age		
17 or younger	12.5	13.2
18-24	8.2	7.6
25-34	6.1	6.5
35-44	4.7	4.8
45-54	4.3	4.1
55-64	4.8	4.8
65 or older	13.8	11.0
Family Income Relative to Poverty Level		
Below 50%	40.6	41.3
50-99%	40.2	35.4
100-124%	20.6	14.1
125-149%	13.8	7.5
150-199%	6.8	4.4
200-299%	3.5	2.0
300% or above	1.3	0.6
U.S. Census Divisions		
New England	8.3	7.3
Middle Atlantic	10.2	10.4
East North Central	8.7	9.4
West North Central	6.5	6.4
South Atlantic	7.3	6.2
East South Central	9.8	9.7
West South Central	7.9	6.5
Mountain	4.0	4.4
Pacific	10.7	10.7

SOURCE: March Current Population Surveys of 1980 and 1984. Medicaid coverage is for the previous calendar year. (Swartz, MPE Working Paper 5.5)

grew as a percent of all children from 12.5 to 13.2 percent, reflecting the 3.7 percent increase in absolute numbers. Coverage of young adults between the ages of 25 and 44 grew slightly, reflecting the fact that the sharp growth in numbers of recipients was also matched by relatively rapid increases in the population of young adults. Medicaid coverage of the elderly declined fairly sharply (from 13.8 to 11.0 percent of the elderly population).

With respect to income, between 1979 and 1983 Medicaid coverage declined for people in all income brackets except those with income below half the poverty line. The percentage of the population with income less than half the poverty line who were also covered by Medicaid increased slightly (from 40.6 to 41.3 percent). However, the proportion of individuals in the income bracket above half the poverty line but still in poverty declined from 40.2 to 35.4 percent. Overall, the increases in the number of people in poverty were not matched by increases in the number on Medicaid; thus, the effect on coverage of the poverty population was a decline from 40.3 to 37.8 percent. Coverage by Medicaid of individuals with incomes above the poverty line declined sharply as one might expect.

There were major differences in the effects on Medicaid coverage by region. Medicaid coverage as a share of the region's population fell fairly sharply in the New England, South Atlantic, and West South Central regions. It remained stable in the Pacific, West North Central, East South Central, and Middle Atlantic regions. And it grew in the East North Central and Mountain regions.

How Much Did the Poverty Population Grow?

The growth in the poverty population and the way that growth was distributed among different groups and regions was also examined by Swartz.

As Table IV.3 shows, there was a 37 percent increase in the U.S. poverty population between 1979 and 1983. Individuals below half the poverty line increased by 66 percent. The number of individuals above half the poverty line but still in poverty also increased but not as much.

The number of people in poverty increased in each region. The proportionate increases in the number of people in poverty were particularly large in the Mountain, the West North Central, Pacific, and the East North Central regions. New England experienced the smallest increase in poverty. The number of people in poverty also increased as a share of each region's population. By 1983, more than 15 percent of each region's population was in poverty, with over 22 percent of the East South Central region's population in poverty.

Young adults appeared to bear the brunt of the poverty increases with a 62.3 percent increase over the 4-year period. The number of children in poverty increased by 35 percent. In contrast, the number of poor elderly barely increased. The result was a substantial increase in the share of children (17.5 percent to 24 percent) and young adults (9.7 percent to 14.6 percent) in poverty.

What Happened to Medicaid Coverage of the Population in Poverty?

State Medicaid programs typically have very different objectives in making decisions on coverage of different groups. Children, for example, are more likely to be covered in States which have AFDC-UP and Ribicoff children coverage. These different objectives make it likely that the extent of Medicaid coverage in relation to income will be different for different groups. Swartz's analysis of the likelihood of coverage for several groups of poor and

Table IV.3

U.S. Population in Poverty
1979 and 1983
(numbers in thousands)

	1979	1983	Percent Change 1979-1983
Total Poverty Population	27,224	37,250	36.8
Percent of U.S. Population in Poverty	12.2%	16.1%	
Age Groups:			
Younger than 18	11,133	14,999	34.7
18-40	7,969	12,964	62.3
41-64	4,407	5,546	25.8
65 and older	3,715	3,740	.7
Family Income Relative to Poverty Level:			
Below 50%	9,411	15,616	65.9
50-74%	7,962	9,975	25.3
75-99%	9,851	11,660	18.4
U.S. Census Divisions			
New England	1,045	1,233	18.0
Middle Atlantic	4,208	5,735	36.3
East North Central	4,261	6,236	46.3
West North Central	1,634	2,678	63.9
South Atlantic	5,162	6,335	22.7
East South Central	2,590	3,302	27.5
West South Central	3,846	4,676	21.6
Mountain	1,177	1,948	65.5
Pacific	3,300	5,108	54.8

SOURCE: Swartz (MPE Working Paper 5.5).

near poor indicates substantial differences among groups, both before and after passage of OBRA.

The patterns of coverage of different groups are shown in Table IV.4. The probability of children being covered by Medicaid declined between 1979 and 1983. In 1979, nearly 50 percent of all children in poverty were covered by Medicaid; the proportion had declined to 46.7 percent by 1983. The decline, which reflects the fact that the number of children in poverty grew faster than did the growth in the number of poor children covered by Medicaid, occurred in every region but the East South Central and Pacific. For children in near-poor families, the proportion covered by Medicaid declined much more, from 18.5 to 9.8 percent. This decline occurred throughout the country.

The proportion of poor women between the ages of 18 to 40 who were covered by Medicaid declined nationally from 46.3 percent to 40.9 percent, and occurred in every region. Coverage of near-poor women in this age group was more than halved, declining from 19 percent to 9.3 percent; the likelihood of being covered in 1983 was less than 6 percent in five of the nine regions.

The patterns for women over 75 years of age are very different. For those below the poverty line, the likelihood of being covered by Medicaid rose slightly between 1979 and 1983, from 31 to 33 percent. For the near-poor women over 75, the likelihood of coverage remained essentially the same.

Has the Medicaid Program Met the OBRA Objective of Becoming More Targeted on the Poor?

One of the stated objectives of OBRA was to limit Medicaid benefits to those who were truly needy. This reflected a concern that many welfare and Medicaid benefits went to individuals above the poverty line. The OBRA eligibility cutbacks were targeted at the working poor, individuals whose incomes

Table IV.4

Percentage of Noninstitutionalized Persons Covered by Medicaid, for Selected Categories, 1979 and 1983

Categories	Families with Incomes Below the Poverty Level		Families with Incomes between 100% and 150% of Poverty	
	1979	1983	1979	1983
Children, Age 0-17	49.5	46.7	18.5	9.8
Women, Age 18-40	46.3	40.9	19.0	9.3
Women, Age 75 and over	31.5	33.4	17.1	16.9

SOURCE: March 1980 and 1984 Current Population Surveys. Medicaid coverage is for the previous calendar year. (Swartz, MPE Working Paper 5.5)

often went above the poverty line. It is clear from Table IV.5 that the proportion of Medicaid recipients who were below the poverty line increased sharply between 1979 and 1983, both for the nation as a whole and for all regions. Nationally, the proportion of Medicaid recipients below the poverty line grew from 57.5 percent to 73 percent. The Pacific, Mountain, and New England regions had the lowest percentage of Medicaid recipients with incomes below the poverty line in 1983, reflecting greater coverage in those regions of individuals above the poverty line. It is important to note, however, that these increases are not because Medicaid covered more of the poor, but because it covered fewer of the non-poor. As columns 3 and 4 reveal, the percentage of the poor covered by Medicaid declined in all but the Pacific region. Nationally, 40.3 percent of the poor were covered in 1979 and 37.8 percent in 1983.

What Were the Net Effects of Increases in Poverty and Reductions in Program Coverage on Eligibility of Children, Young Adults, and the Elderly?

The noninstitutionalized Medicaid population grew by 210,000 people between 1979 and 1983. As Swartz indicates, this represents a 1 percent increase in the size of the Medicaid population, and contrasts sharply with a 37 percent increase in the number of people in poverty during the same period. The 1 percent increase reflects the offsetting impacts of not only the growth in the poverty population due to the recession of 1981 and 1982 but also the program cutbacks resulting from AFDC eligibility changes in OBRA, TEFRA, and DEFRA. If the OBRA-mandated changes in eligibility had not been implemented, many more than 210,000 additional people would have been covered by Medicaid as a result of the recession.

Table IV.5

Targeting Medicaid Coverage on the Poor

U.S. Census Divisions	Proportion of Medicaid Population in Each Region with Family Income Below the Poverty Level		Proportion of Total Population with Family Income Below the Poverty Level Covered by Medicaid	
	1979	1983	1979	1983
New England	52.9	64.6	50.7	47.9
Middle Atlantic	61.5	78.1	54.7	52.0
East North Central	56.6	76.3	47.7	47.7
West North Central	48.7	70.4	32.6	28.7
South Atlantic	65.2	76.2	33.6	28.4
East South Central	68.1	79.3	37.0	34.6
West South Central	68.2	78.0	32.3	27.8
Mountain	55.7	63.4	20.9	17.3
Pacific	41.9	61.5	42.4	43.4
Total	57.5	73.0	40.3	37.8

SOURCE: March Current Population Surveys of 1980 and 1984. Medicaid coverage is for the previous calendar year. (Swartz, MPE Working Paper 5.5)

The number of children on Medicaid grew by 3.7 percent at the same time that the number of children in poverty grew by 35 percent. The relatively small growth in the number of children enrolled in Medicaid reflects program cutbacks, which particularly affected children in families with incomes above the poverty line. The number of children below the poverty line who were covered by Medicaid increased but not as fast as the growth in numbers of children in poverty; thus, the proportion of poor children on Medicaid fell from 49 to 46 percent.

The number of young women on Medicaid increased much more, at rates close to 20 percent. But this increase was far outstripped by an increase of over 60 percent in the number of young women in poverty during this period. The implication is that the likelihood of being on Medicaid for this group declined. For young women in poverty, the probability of being on Medicaid declined from 46.3 percent in 1979 to 40.9 percent in 1983; for those just above the poverty line, it declined from 19.0 percent to 9.3 percent for women.

The number of aged Medicaid recipients declined sharply, particularly for those aged 65-74. The proportion of elderly Medicaid recipients in poverty declined as well, therefore reducing the number meeting Medicaid eligibility requirements. The likelihood of an elderly person in poverty being enrolled in Medicaid, however, did not decline significantly.

What Were the Impacts of Losing Medicaid Eligibility on Health Insurance Coverage and Health Service Utilization?

Among those families rendered ineligible for Medicaid by OBRA, approximately one-half were successful in replacing Medicaid with group health insurance (Long and Settle, MPE Working Paper 5.4). The remaining one-half of these families were left with no insurance coverage at all.

Other studies have also found substantial proportions without insurance. Moscovice and Craig (1983) reported that approximately 25 percent of those off AFDC and working, and approximately one-third of their children, did not have health insurance coverage in January 1983, a year after termination.[1] Only 1 percent of this group bought private health insurance directly, presumably due to its high cost. Those with private health insurance through work had considerably weaker coverage than those still on Medicaid. Those off Medicaid and working paid over half of their health care bills out of pocket, and reported delaying seeing physicians and dentists significantly more often than those who remained on AFDC. The General Accounting Office reported that terminated Medicaid recipients obtained private insurance in only 25 percent of the AFDC cases in Dallas and Memphis and between 57 percent and 67 percent of the cases in Boston, Milwaukee, and Syracuse.[2] Sixty percent of the respondents in Dallas had no coverage at all for themselves or their children; in Memphis 60 percent of the parents and 50 percent of their children had none.

Long and Settle also addressed the question of reduced access due to loss of Medicaid coverage. Of those who lost Medicaid eligibility in 1981, an estimated 55 percent acquired private insurance, and an estimated 45 percent were left with no coverage at all. Individuals who lost Medicaid coverage but acquired private insurance were not predicted to experience statistically significant declines in the use of ambulatory physician services, inpatient hospital services, or prescription drugs. In contrast, the 45 percent with no

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1. Ira Moscovice and William Craig, "The Impacts of Federal Cutbacks on Working AFDC Recipients in Minnesota," unpublished paper, December 1983.

2. General Accounting Office, "An Evaluation of the 1981 AFDC Changes: Initial Analysis," Washington, D.C., April 2, 1984.

insurance coverage were predicted to experience large, statistically significant declines in their use of these health services over time: an estimated reduction of 38 percent in their use of physician services, of 71 percent in their use of inpatient hospital services, and of 39 percent in their purchase of prescription drugs. Loss of coverage for dental services was estimated as resulting in a 61 percent reduction in use for those without insurance. However, because 92 percent of those losing Medicaid were estimated to have acquired no dental coverage, the effect of a large reduction in use can be expected to apply to virtually all those who lost Medicaid coverage, whether or not they acquired other insurance.

These estimates of substantial drops in utilization depend on the Medicaid coverage variable truly capturing a behavioral response to lower out-of-pocket prices. If in fact the Medicaid population is really different in, for example, its health status, racial characteristics, or non-financial barriers to utilization, then the estimated effect on utilization may be somewhat overstated.

Summary

This chapter described the impact of the 1981 OBRA legislation on Medicaid enrollment by examining the periods immediately before and after the passage of the legislation. How much did OBRA's provision reduce Medicaid enrollment? In the year following the OBRA legislation, there was a reduction in Medicaid enrollment of about 5 percent. The independent impact of OBRA is estimated to be considerably greater--accounting for a reduction of about 13 percent in Medicaid enrollment. Population growth and the economic recession worked to increase the number of persons eligible, and thus offset the impact

of OBRA resulting in a smaller net reduction. The reductions in enrollment were estimated to have saved the government approximately $900 million.

Over the period from 1979 to 1983, the noninstitutionalized Medicaid population increased by slightly more than 200,000 people. This 1 percent increase in enrollees masks important compositional changes in enrollees by income. In 1979, 57.5 percent of Medicaid enrollees had family incomes below the poverty line. By 1983, this percentage had risen to 73 percent. This increase was not a result of Medicaid covering more poor, but rather Medicaid covering less of the non-poor. This reflects OBRA's objective of reducing Medicaid enrollment of the working poor and near-poor. This change is also evident in the changes in the proportion of income groups receiving coverage. Overall, the total percentage of the U.S. population covered by medicaid declined slightly from 8.6 percent in 1979 to 8.3 percent in 1983. Those with incomes below 50 percent of the poverty line were slightly more likely to receive Medicaid as coverage of this group increased from 40.6 percent to 41.3 percent. However, those with incomes between 50 percent of the poverty line and the poverty line experienced a decline in coverage from 40.2 percent to 35.4 percent. Overall, the increases in the number of people in poverty (all those below the poverty line), was not matched by increases in Medicaid enrollment. Thus, coverage of the poor declined from 40.3 percent to 37.8 percent. Coverage of people above the poverty line declined even more sharply as expected by OBRA's emphasis on shifting coverage away from the working poor and near-poor.

The compositional changes over the period can also be seen among the eligibility categories of children, young adults, and the elderly. Children and young adults were most likely to be affected by the changed environment.

The number of children on Medicaid increased by less than 4 percent at the same time that the number of children in poverty grew by 35 percent. These numbers reflect a small reduction in the likelihood of poor children being covered by Medicaid programs, and a large reduction in the likelihood of Medicaid coverage of children in families with incomes above the poverty line.

The number of young adults, primarily women, on Medicaid increased by almost 20 percent, but this increase was much less than the increase in the number of young adults in poverty of over 60 percent. As with children, the likelihood of being on Medicaid declined. Again, this is particularly true of young adults with family incomes above the poverty line.

In contrast to children and young adults, the number of elderly Medicaid recipients declined sharply, particularly for those aged 65 to 74. Over the same period, the proportion of elderly Medicaid recipients in poverty also declined, reducing the number meeting Medicaid eligibility standards. As a result, the likelihood of being on Medicaid did not decline significantly for the elderly.

As demonstrated earlier, the retargeting of the Medicaid program on the non-working poor left many of the working poor and near-poor without health insurance, and the huge increase in the poor population outstripped the modest increase in Medicaid enrollees from this population. What happened to these individuals in terms of their health insurance and utilization? Approximately half the individuals losing Medicaid eligibility were able to replace Medicaid with group health insurance. The remainder did not appear to obtain insurance coverage at all. The individuals losing Medicaid eligibility who did not obtain health insurance coverage were predicted to experience extremely large reductions in utilization of physician services, inpatient hospital services, and use of prescription drugs.

V. HOSPITAL REIMBURSEMENT

About one-quarter of all Medicaid expenditures are for inpatient hospital care. The 1981 OBRA legislation gave States greater flexibility and authority over their hospital payment methods, by making it easier for States to adopt alternatives to retrospective cost-based principles of hospital reimbursement. Prior to OBRA, Medicaid hospital reimbursement was linked to Medicare's cost-based principles; OBRA's increased flexibility followed by the establishment of Medicare's prospective payment system (PPS) have opened an era of innovation in hospital reimbursement for the States.

OBRA 1981 removed a major barrier to States developing more efficient reimbursement systems by eliminating the requirement that their Medicaid programs use Medicare cost-based reimbursement principles to pay for hospital care. Instead, States were allowed to establish reimbursement systems in which the rates they paid:

- were sufficient to cover the costs of an efficient and economically operated facility;

This chapter summarizes findings presented in Joel Cohen and John Holahan, "Medicaid Eligibility After the Omnibus Budget Reconciliation Act of 1981," MPE Working Paper 5.1; Jerry Cromwell and Sylvia Hurdle, "National Impact Study of Alternative Medicaid Reimbursement Waivers: Second Annual Report," MPE Working Paper 3.6; Michael Koetting and Lois Olinger, "Selective Contracting in California: The First Year," MPE Working Paper 3.1; Holly Korda, "Innovations in Medicaid Hospital Reimbursement: Refining Prospective Payment in the Eighties: Summary of State Programs," MPE Working Paper 3.5; Stephen Mennemeyer, Lois Olinger, and Larry Forgy, "Final Report: Medicaid Program Evaluation (Cluster 11): Hospital Inpatient Reimbursement," MPE Working Paper 3.8; Lois Olinger et al., "Medicaid Alternative Hospital Reimbursement in Three States: Pennsylvania, Illinois, Texas," MPE Working Paper 3.7; Michael Koetting and Holly Korda, "Medicaid Hospital Reimbursement in New Jersey," MPE Working Paper 3.4; and Stephen Zuckerman, "Medicaid Hospital Spending: The Effects of Reimbursement and Utilization Control Policies," MPE Working Paper 7.4.

- gave consideration to hospitals serving a "disproportionate" share of poor patients; and
- resulted in overall inpatient hospital spending that is not greater than the amount paid if Medicare reimbursement principles were used.

These legislative changes allowed States a unique opportunity to control a major component of their Medicaid expenditures by developing reimbursement systems with stronger incentives for cost control.

This chapter examines State Medicaid policies toward hospital payment since OBRA's enactment.

Data Bases and Methodology

A wide variety of data sources was used in both a quantitative and a qualitative analysis of State hospital reimbursement methods. A key source of data for detailed analysis in both California and New Jersey was State hospital cost reports. These reports provided financial and utilization information on a hospital level, and in many cases by cost centers. In California, a one-week sample of Medi-Cal claims was drawn in January of 1983 and 1984 in order to avoid possible seasonality distortions in the comparisons. The two one-week samples contained about 12,000 inpatient claims and about 76,000 outpatient claims. In New Jersey, the Health Research and Educational Trust of New Jersey compiled annual hospital-level summaries by payer. Payer summary files for 1979, 1982, and 1983 were used in the New Jersey analysis.

The cost, claims, and payer data were merged with demographic and hospital characteristics information in multivariate analyses. This provided controls for such measures as teaching status and location of the hospital, and for changing casemix of the hospital population. The multi-year nature of the dataset allowed for comparison of hospital performance both before and

after institution of a new hospital payment system. Particular attention was focused on measures of cost per case, length of stay, mortality rates, admissions, and hospital market shares.

In addition to the quantitative analyses of California and New Jersey, case studies were done of reimbursement systems in Illinois, Texas, Pennsylvania, California, and New Jersey. These involved site visits and extended interviews with hospital administrators and health care providers, other members of the health care community, and officials in the State Medicaid programs. National analyses of the effects of OBRA upon State Medicaid spending for hospital services were undertaken using data reported by the States to HCFA on Form 2082 for the period from 1978 to 1984.

How Did State Reimbursement Policies Change After Passage of OBRA?

Prior to the enactment of OBRA, the Medicaid program was required to reimburse hospitals on the basis of their actual cost of operations in accordance with accounting standards developed by the Medicare program. These accounting rules have weak incentives for cost containment because the costs of labor, materials, and capital inputs would be fully reimbursed. To counteract these inflationary incentives, prospective rate-setting programs were developed to set a hospital's reimbursement rate (either per day or per admission) at a fixed level at the start of a year; the hospital would then be at risk to keep its costs at or below this rate. If the hospital was successful, it would be allowed to retain as profit some of the difference between its costs and the payment rate; if unsuccessful, it would have to absorb some of the difference as a loss. During the 1970s, 15 States developed programs of prospective rate setting, which covered at least one major third-party payer of hospital care;

Medicaid participated in nine of them. These programs were generally successful at reducing the rate of increase in hospital costs inflation by one to three percentage points per year.[1]

The small number of States that undertook these programs during the 1970s reflects a variety of obstacles: initial uncertainty about whether or not prospective reimbursement would be successful, lack of experience in designing and implementing such programs, and the administrative complexities associated with obtaining Medicaid waivers. The passage of OBRA allowed States greater flexibility in replacing Medicare's cost-based methods. Subsequent passage of TEFRA and the adoption of a Diagnosis Related Group (DRG) payment system by Medicare under its prospective payment system gave further impetus for States to innovate.

The historical record shows that States rapidly took advantage of the economizing opportunities offered by OBRA (1981) and subsequent legislation. As of October 1, 1985, four years after OBRA, all but 8 States had changed their reimbursement systems, most to some prospective payment system. Five major types of reimbursement systems were in effect in State Medicaid programs as of October 1, 1985.

Retrospective Cost-Based Reimbursement. This is the system mandated (except with waiver exceptions) prior to OBRA. It was in effect in all but four States in 1977. Basically, this system reimburses a hospital for its actual cost of rendering care as determined by a retrospective audit of costs. (Typically an interim rate is used to pay a hospital throughout the year in

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1. Craig Coelen and Daniel Sullivan, "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," Health Care Financing Review, Winter 1981.

which it renders care; a final payment is then made based on the audit.) As noted, only 8 States still had this system as of October 1, 1985.

Retrospective Cost to Trend Limit. Under this system a hospital is paid its actual costs up to a limit on the allowed rate of increase in the reimbursement rate. There are two variants. One bases the limit on regional or national inflation experience. The second bases it on two factors: the rate of inflation in inputs and the rate of cost increases experienced by other peer hospitals. Eight States and the District of Columbia had a trend-limit system as of October 1, 1985.

Prospective (Base-Trended) Reimbursement. Under this system, a hospital's reimbursement depends upon its costs in a base year plus an allowance for annual inflation. A hospital's actual costs in years beyond the base have no effect on reimbursement. If actual costs are less then the prospective rate, the hospital profits; if actual costs exceed the prospective rate, the hospital incurs a loss. This system rewards hospitals that keep their costs lower than the allowed trend. A minor variation on this system groups hospitals according to bed size, teaching status, urban or rural location, etc., and trends the base costs for each group forward to establish a prospective rate. Twenty-two States had a base-trended system as of October 1, 1985.

Prospective Flat Rate or DRG System. Hospitals are paid a fixed amount per admission for each case with a particular diagnosis. The fixed rate may vary for particular types of hospitals such as teaching hospitals or those in rural areas. Most Medicaid DRG systems are variations of the Medicare system which pays according to 471 (1987) diagnosis related groups (DRGs). Hospitals receive a payment per case which is equal to the industry average cost of treatment for each diagnosis regardless of length of stay or other measures of utilization. On average a hospital should have its costs fully covered by

this system, but hospitals can profit or incur loses to the extent that their costs of treatment are lower or higher, respectively, than the industry average. Cases which exceed a defined limit on costliness are reimbursed separately based on a percentage of costs. Ten States had implemented DRG systems as of October 1, 1985.

Prospective Rate via Contracting or Negotiation. Under this system the State tries to negotiate a favorable reimbursement rate. The systems may be viewed as variants of competitive bidding except that the systems are often more flexible in negotiating than is typical in a sealed bid situation. Four States used this system as of October 1, 1985, often in combination with other techniques. In two States (California and Illinois), for example, the State's negotiating power is enhanced by its power to refuse to award contracts to hospitals which offer relatively high rates.

Figure V.1 shows the 1985 pattern of reimbursement systems across States. Figure V.2 shows the timing of the shift. There has been a clear and dramatic shift away from retrospective systems toward prospective systems. States have embraced prospective systems in the belief that they impose a more severe budget discipline on hospitals. The next section examines the actual experience of the States in terms of their cost inflation under retrospective versus prospective systems. The findings generally support the belief that prospective systems are more effective than retrospective systems at reducing the rate of growth in costs.

Did Prospective Payment Systems Impose Discipline on Hospital Spending?

To estimate the effect of prospective payment on hospital spending States were divided into three groups according to reimbursement method pre- and

Figure V.1

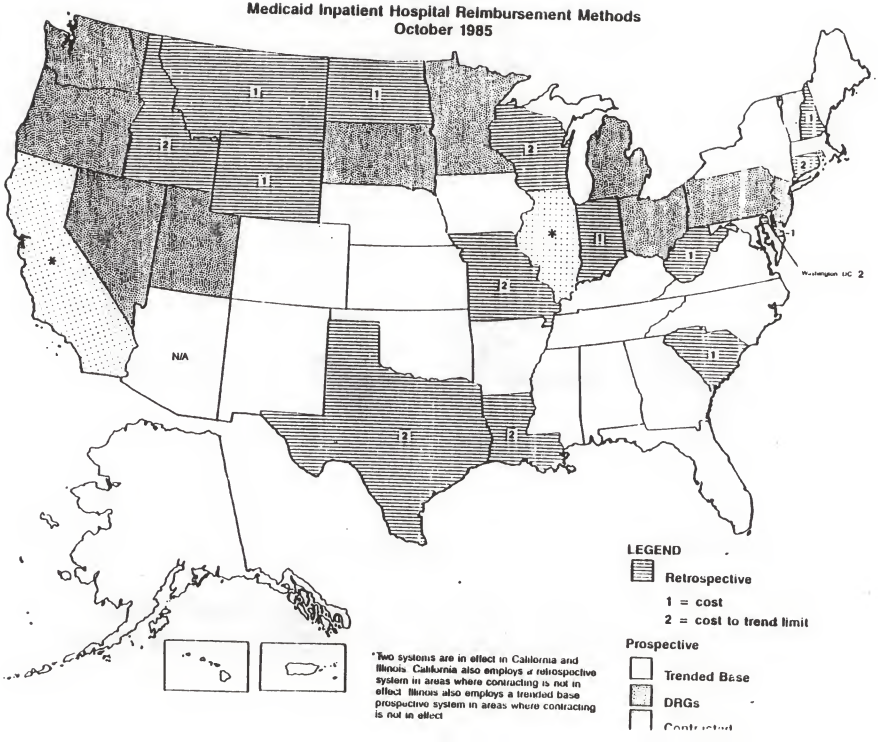
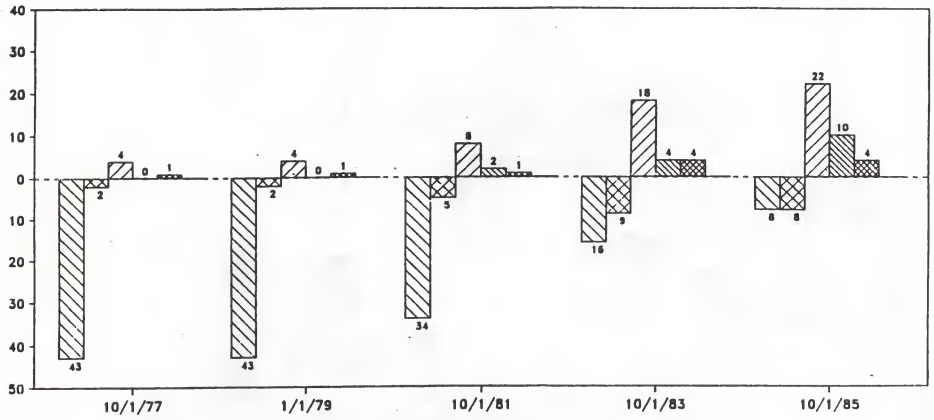

Medicaid Inpatient Hospital Reimbursement Methods
October 1985
N/A
Washington DC 2
LEGEND
Retrospective
1 = cost
2 = cost to trend limit
Prospective
Trended Base
DRGs
Contractual
*Two systems are in effect in California and Illinois. California also employs a retrospective system in areas where contracting is not in effect. Illinois also employs a trended base prospective system in areas where contracting is not in effect.

Figure V.2

PROSPECTIVE HOSPITAL REIMBURSEMENT

Trends in State Medicaid Programs, 1977 – 1985



KEY:

RETROSPECTIVE METHODS

- Cost
- Cost to Trend

PROSPECTIVE METHODS

- Base Trended
- DRG
- Contract/Negotiation

post-OBRA: States using traditional retrospective Medicare reimbursement methods throughout the 1978-1984 period, States implementing "early" rate-setting schemes prior to OBRA, and States implementing "late" rate-setting schemes after OBRA's enactment (Cromwell and Hurdle, MPE Working Paper 3.6). Growth rates in actual hospital spending, actual hospital spending per patient, and number of patients are shown for the three groups in Table V.1.

All three groups of States experienced lower rates of increase after than before OBRA. As expected, the largest drop in the rate of increase after OBRA and the lowest post-OBRA rate of increase occurred in States which implemented late rate-setting reimbursement systems. These States more than halved their inpatient expenditure growth between pre- and post-OBRA periods. Because the number of recipients of hospital services decreased in the post-OBRA period, expenditure growth reductions were considerably smaller on a per recipient basis. Per recipient expenditure growth rates decreased the most (38 percent) between the pre- and post-OBRA periods for States with early rate-setting systems and the least (22 percent) for States which retained the cost reimbursement system throughout.

Examining hospital expenditure growth for AFDC and SSI eligibles separately revealed some differences between reimbursement groups on a per recipient basis. AFDC inpatient expenditure growth rates decreased for States with late rate-setting systems and States that continued to employ traditional cost reimbursement methods. It remained virtually constant between the pre- and post-OBRA periods for States that adopted early rate-setting systems, although the growth rate was low enough pre-OBRA to remain comparable with post-OBRA growth rates for the other groups. This stems largely from a substantial decrease in the number of AFDC inpatients in those States during

Table V.1

Average Annual Growth in Medicaid Inpatient Hospital Expenditures for Pre- and Post-OBRA Periods, by Reimbursement System

	Expenditures		Expenditures Per Inpatient		Inpatients	
	1978-1981	1981-1984	1978-1981	1981-1984	1978-1981	1981-1984
Average Annual Compound Growth Rates in Hospital Expenditures						
Total U.S.	15.0	7.3	13.7	9.4	1.2	-2.1
Pre-OBRA (Early) Rate-Setting States	14.1	7.2	14.6	9.1	-0.5	-2.0
Post-OBRA (Late) Rate-Setting States	14.9	6.6	13.5	8.9	1.4	-2.3
Medicare Reimbursement States	15.6	8.7	13.5	10.5	-2.1	-1.8
Average Annual Compound Growth Rates in Hospital Expenditures - AFDC						
Total U.S.	14.5	6.2	12.5	8.8	1.9	-2.6
Pre-OBRA (Early) Rate-Setting States	9.4	5.3	9.9	9.3	-0.6	-4.5
Post-OBRA (Late) Rate-Setting States	15.2	5.1	13.0	8.3	2.2	-3.2
Medicare Reimbursement States	16.3	8.7	13.3	9.3	3.0	-0.6
Average Annual Compound Growth Rates in Hospital Expenditures - SSI						
Total U.S.	16.5	7.5	14.5	9.9	2.6	-2.3
Pre-OBRA (Early) Rate-Setting States	17.7	8.1	17.2	9.1	0.5	-1.1
Post-OBRA (Late) Rate-Setting States	15.7	6.6	13.7	9.0	2.0	-2.4
Medicare Reimbursement States	17.5	9.0	14.3	12.1	3.3	-3.1

SOURCE: Cromwell and Hurdle (MPE Working Paper 3.6).

the post-OBRA period. By contrast, the same States exhibited a larger decrease in SSI hospital expenditure growth on a recipient basis in the post-OBRA period than in late rate-setting or cost reimbursement States.

Another study (Zuckerman, MPE Working Paper 7.4) used the same Medicaid hospital expenditure data to analyze the effects of different rate-setting approaches on the rate of growth of Medicaid hospital expenditures. States were classified according to whether they controlled only Medicaid rates, Medicaid plus some other payers' rates, or rates paid by all third-party payers. The study also differentiated the Medicaid-only rate-setting systems according to the length of time they had been in place.

The first evaluation objective was to distinguish between all-payer, multi-payer, and Medicaid-only systems in their effects on Medicaid outlays. The second objective was to test whether different payment systems (1) had effects which lasted beyond a one-time initial impact and (2) had their effects through reducing the number of recipients rather than services per recipient. The study used eight years of Medicaid expenditure data, 1977 through 1984. Aged Medicaid patients were excluded because virtually all of these patients are also Medicare eligible; thus, their inpatient hospital utilization and payments will be affected by Medicare reimbursement rules rather than State policy decisions.

In addition to reimbursement policy, States employed a wide variety of controls in their attempts to limit both hospital admissions and lengths of stay, e.g., prior authorization, limits on hospital stays, etc. In order to isolate the effect of reimbursement changes, multivariate analysis controlled for the effect of these other variables, for changes in Medicaid eligibility, and for general trends affecting the hospital sector.

The results shown in Table V.2 indicate that the all-payer States had statistically significant lower rates of growth in hospital spending, averaging 6.1 percent annually. Medicaid-only rate-setting systems had strong effects in the first full year of implementation, averaging a 7.6 percent reduction in the rate of growth of real Medicaid hospital spending; however, the effect did not continue in subsequent years. The implication is that Medicaid-only systems have a strong one-time effect, but then return to the same growth rate they were experiencing prior to the reimbursement change. The lower growth rates of all-payer States continued through the whole analysis period, which went beyond at least the third year of implementation, indicating the likelihood that they are long-term effects. The persistence of the effect on spending over the whole observation period is consistent with other evidence on rate-setting effects when all payers are covered.

The details of the rate-setting systems in the four all-payer States (New York, Massachusetts, New Jersey, and Maryland) suggest that the systems in the first two are more stringent than those in the second two. To see whether greater stringency did indeed have greater effects on hospital spending, the average effect for New York and Massachusetts was estimated separately from the average effect for New Jersey and Maryland. As expected, the New York and Massachusetts systems accounted for almost all the effect in the all-payer States.

There were no effects on hospital spending growth in States where Medicaid and some, but not all, payers were included in the rate-setting system.

As noted, there were effects in States where only Medicaid was covered, but these were confined to an average reduction of 7.6 percent in the first full year of implementation, slightly more than half of which was due to a

Table V.2

Effects of Reimbursement Changes on Inflation-Adjusted Medicaid Hospital Spending, 1977-1984
(Average Annual Percent Change in Medicaid Spending)

	Hospital Spending	Medicaid Inpatient Recipients	Spending per Medicaid Inpatient Recipient
All-Payer Systems	-6.1**	-1.0	-5.9**
Other Multi-Payer Systems	-5.1	-3.0	-2.8
Medicaid-Only Systems			
First full year	-7.6**	-4.2*	-3.9
Subsequent period	-0.5	-0.1	-0.3

SOURCE: Medicaid expenditure data (Zuckerman, MPE Working Paper 7.4).

** Statistically significant at the .05 level.
* Statistically significant at the .10 level.

reduction in spending per inpatient recipient. That the effect was confined to the first full year in States where rate-setting covered only Medicaid may suggest that States, having successfully achieved a sharp reduction in the growth of hospital spending, may become somewhat less stringent in their application of the new system, for fear of restricting access to hospital care for Medicaid recipients. Even this one-time impact is a significant achievement, because although spending growth returned to its previous rate, levels of spending remained lower.

* * *

So far we have been comparing the effects of different Medicaid payment systems at a relatively aggregate level. The rest of the chapter looks in detail at two types of system. The first is selective contracting, which is the most dramatic departure from traditional hospital payment methods. The second is the DRG system, which was adopted for the Medicare program and is being implemented increasingly by State Medicaid programs.

What Is Selective Contracting?

Selective contracting is essentially a variant of competitive bidding. The State Medicaid program asks hospitals to submit bids for serving Medicaid cases; those hospitals with bids in the lower range are then selected for further negotiations and eventual award of a service contract. All hospitals wishing to treat Medicaid patients under such a system are faced with an incentive to offer Medicaid as low a bid as they can afford.

Selective contracting reverses the dynamics of traditional rate-setting programs. In traditional rate setting, the State has to propose a rate formula and justify it as reasonable in a highly charged political arena. The

State is at a disadvantage in this setting because, although the State may have good reason to suspect that hospitals could achieve more economies (and therefore lower costs), it is very difficult to prove that a given rate structure is indeed reasonable under conditions of efficient operation. As a consequence, most rate-setting programs have limited their rate-setting efforts to not allowing hospital rates to rise faster than some measure of other prices.

Selective contracting forces hospitals to take the initiative in discovering how to lower their costs and to pass on to the State (at least some of) these savings via a relatively low bid. The focus of pricing thus shifts from simply limiting the rate of annual inflation to one of justifying a hospital's level of prices relative to its competitors. From a political perspective, the State is no longer in the position of having to justify why it pays a particular rate to a particular hospital. A hospital is paid on the basis of its bid, which presumably reflected the hospital's own calculation of reasonable reimbursement.

From a theoretical perspective, a competitive bidding system is attractive because it encourages bidders to reveal to the State their true economic costs of operation--not above cost, nor (and this is important) below cost. Most hospitals are nonprofit institutions, but this does not mean they only charge true costs. Economic analysis suggests that nonprofit hospitals earn "quasi-profits". That is, they employ more staff, use more materials, build nicer buildings and incur more bad debts on their patients (that is, they render more charity care) than they would if they were profit seeking institutions in a competitive market. They may also provide a range of specialized services for which there is a limited demand (i.e., services which may be

highly valued by the community but for which revenues do not equal costs). There are certain social inefficiencies in this situation in the sense that the extra resources used by hospitals might be more socially valuable if used by other sectors of the economy to provide, for example, housing or education. Competitive bidding can be viewed as a device to lessen the level of quasi-profits in the hospital sector.

Whatever the theoretical advantages, however, application of competitive bidding in the form of selective contracting with hospitals for providing Medicaid services raises some difficult questions about what the incentives actually will be. What if selective contracting encourages hospitals to bid "below cost" on Medicaid work and cover the excess cost by charging prices that are "above cost" for other payers? Can such behavior persist in the long run? What would happen if all other payers also resorted to competitive bidding? Answers to these questions hinge on the distinction between average cost (i.e., total costs averaged across all services) and marginal cost (i.e., the direct cost of providing an additional service) and on the extent to which hospital costs really have imbedded in them an element of inefficiency or quasi-profit.

If hospitals attempt to maximize quasi-profits across all payers, and if Medicaid competitive bidding forces hospitals to reduce the level of quasi-profits, under selective contracting a hospital might reduce its Medicaid prices. It would not necessarily reduce its prices to other payers if they did not press the hospital to do so. Under sufficiently aggressive bidding for Medicaid work, the hospital might even reduce its price to Medicaid enough to eliminate all of its quasi-profits without in any way reducing its prices to other payers. In this context, other payers are disadvantaged only in the

sense that Medicaid has captured some of the reduction in quasi-profits that other payers might have been able to capture if they, too, had engaged in competitive bidding. This line of analysis suggests that Medicaid's initial successes with selective contracting may be lessened if other payers also begin to engage in some form of competitive bidding. It should also be emphasized that reduction in quasi-profits may well mean reduction in specialized services provided by hospitals, less indigent care, etc.

If, in contrast, there are no quasi-profits, selective contracting may encourage hospitals to give Medicaid bids that reflect the direct (marginal) cost of the Medicaid services on the assumption that prices to other patients will be sufficient to cover hospital overhead. Encouraging hospitals to bid the marginal cost in this manner is a sound pricing strategy if Medicaid patients in fact fill up beds that would remain empty if the hospital were an unsuccessful bidder. However, as in the previous case, if other payers also engage in some form of competitive bidding, Medicaid's ability to get a bid based on marginal cost will be lessened.

The final possibility is that some hospitals have higher real resource costs for reasons that may not be important to delivering care to most of the Medicaid patients. In this case, selective contracting may stimulate the lower cost hospitals to bid successfully, and Medicaid would simply redistribute patients into less expensive hospitals with no fundamental changes in hospital efficiency or in comparative prices across payers. Medicaid achieves savings, however, simply by careful shopping for appropriate hospital beds.

Two States have implemented selective contracting for Medicaid inpatient services. California was the first to implement such a system and is now in its fourth year under the Selective Contracting Program. Illinois, following

California's lead, instituted the Illinois Competitive Access and Reimbursement Equity (ICARE) program following authorizing legislation passed in 1984. Their first fiscal year of operation (1986) recently came to a close.

California. The California system came into being as the result of a severe fiscal crisis in 1982, exacerbated by declining Federal reimbursement rates for Medicaid. The California legislature undertook a major reform of California's Medicaid program, known as Medi-Cal. Among the measures adopted was authorization to negotiate contracts with hospitals for treating Medi-Cal beneficiaries on an inpatient basis. OBRA encouraged this reform by promoting alternative hospital payment systems and allowing waivers of freedom-of-choice and other requirements. California acted quickly, submitting waiver requests to HCFA in July 1982--eleven months after OBRA's enactment. The program went into effect with HCFA approval in the winter of 1982-1983.

Selective contracting could have been implemented under a number of different scenarios. California chose a combination of elements that simplified administration and expedited the negotiations. First, the State chose to use the contract bidding mechanism to lower the rates of hospitals already serving Medi-Cal beneficiaries rather than seeking to channel beneficiaries away from the Medi-Cal hospitals with higher costs. Second, the State opted to negotiate bids based on an all inclusive per diem rate. Alternatives--such as Medicare's DRG-based, per admission rates--were considered too administratively complex given that hospitals had previously been paid on a per diem basis.

While most hospitals did not seek to expand their Medi-Cal business, all but 11 percent of California hospitals entered the bidding process. Some bids were designed to preempt public relations or Certificate-of-Need difficulties

rather than being serious contenders. But hospitals with substantial Medi-Cal business bid seriously. In case study interviews, the most common theme expressed by hospitals in explaining their participation was their need to protect the share of their income associated with Medi-Cal. Even if Medi-Cal was a minority payor, these hospitals could not afford to lose, say, 10 percent of revenue in one fell swoop. Other considerations--such as protecting bond ratings and preserving the hospital's historic role--served to reinforce the compelling economic case. In the end, hospitals accounting for 87 percent of historical Medi-Cal inpatient business made contracts with the State during the first year of contracting.

Illinois. The decision to implement selective contracting in Illinois also grew out of a fiscal crisis in the early 1980s. Illinois attempted to deal with it initially through a series of revisions in its retrospective reimbursement policies. Continuing budget problems, dissatisfaction with retrospective reimbursement, the passage of OBRA, and the example of California finally induced the more drastic shift to selective contracting.

Illinois patterned ICARE after California's selective contracting program, but with several key differences. The major features of the two programs are set forth in Table V.3. As can be seen, both States opted to reimburse based on a per diem basis, and the process of negotiations in both States was similar. The contracting authority completed negotiations by region (Health Facilities Planning Areas). Rural areas with few providers or Medicaid recipients were not put under contracting and continued to obtain Medicaid reimbursement through various retrospective methods.

However, Illinois formally sought to channel patients to lower cost institutions, whereas California did not. California chose to use its long-

Table V.3

Selective Contracting in California and Illinois

	California (effective Feb. 1983)	Illinois (effective June 1985)
Unit of Reimbursement	Per diem - all-inclusive rate, or - separate acute and specialty care rates	Per diem - all-inclusive rate, or - separate acute and special care rates
Volume	No volume cap—relied on utilization review	Negotiated volume cap
Payers Covered	Medicaid	Medicaid
Eligible Hospitals	General acute care hospitals in the the State	General acute care hospitals in- and out-of-State
Goals	Reduce Medicaid expenditures	- Reduce Medicaid expenditures - Shift care from high-cost to low-cost hospitals
Administrative Authority	- DHS: Administration and Monitoring - CMAC: Negotiating Contracts	OHS: Administration, monitoring, and negotiating contracts
Negotiators	CMAC hired full-time staff with health services background. First-year Cost: $1.2 million	OHS hired professional negotiators as consultants
Contracting Areas	HFPAs in which a sufficient number of hospitals existed to compete	HFPAs in which a sufficient number of hospitals existed to compete
Award Criteria	- Access - Adequate availability of routine and specialty care - Variations in casemix - Utilization controls	- Access - Adequate availability of routine and specialty care - Variations in casemix - Disproportionate share hospitals - Teaching costs considered a pass-through
Contract Period	Indefinite	2 years
Confidentiality of Negotiated Rates	Negotiations and rates confidential	Negotiations confidential, final rates public
Legal Challenges So Far	One lawsuit from hospital wanting contract	None

DHS: Department of Health Services
CMAC: California Medical Assistance Commission
OHS: Office of Hospital Services
HFPAS: Health Facility Planning Areas

standing utilization review capability to control volume and utilization, whereas Illinois opted for an overall volume cap combined with a modest utilization review program. Information available to bidders following the procurement also differed. California's process is more confidential—the contracted rates are not public information as in Illinois. In addition, the contracts are for an indefinite period in California, for two years in Illinois.

Perhaps the most important dimension along which the two programs differ is the way the State structured the reimbursement levels that were to be negotiated. California sought bids for price, uncoupled from any volume constraint (except as the hospital sought to limit its Medi-Cal population). Illinois, by contrast, considered price and volume terms in the negotiations, deliberately negotiating smaller volume caps (relative to historical volumes) for higher-priced hospitals (typically, teaching and specialty institutions) and larger volume caps with community hospitals charging lower prices.

Based on the rates and volumes negotiated, the Illinois Hospital Association estimated a 6 percent reduction in Medicaid spending during the first year, with volume shifting accounting for roughly one-quarter of the estimated savings. The inevitable practical problem of Medicaid patients coming for treatment at a hospital that had reached its cap were resolved by a variety of ad hoc arrangements (e.g., adding hospital days). Whether such problems can continue to be resolved in a way that permits continued savings and what impacts the system has on other payers and on recipients, are questions that can only be answered as the system matures.

The four years of implementation in California do permit some assessment of the longer-term impacts of its Selective Contracting Program.

What Have Been the Impacts of Selective Contracting in California?

Both qualitative and quantitative analysis strategies were used to assess the impacts of California's selective contracting on Medi-Cal payments and utilization, the impact on access and quality of care of recipients, and relative prices facing other payers. The qualitative assessment was based on the case study. The quantitative analysis was based on data on month-of-service hospital inpatient claims and hospital inpatient and outpatient patient claims.[1] The sample excludes hospitals in areas where contracting is not in effect as well as certain specialty, Children's, and Federal hospitals.[2]

Medi-Cal Payments and Utilization. Selective contracting achieved substantial savings in Medi-Cal expenditures. Analysis of month-of-service hospital claims estimated that per diem rates paid for services offered after contracting were about 16 percent lower than they would have been without contracting (Koetting and Olinger, MPE Working Paper 3.1).

The degree of rate reduction was not equal across all hospitals or types of hospitals. By far the greatest savings were extracted from teaching hospitals. County hospitals, in contrast, experienced rate reductions

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1. Month-of-service claims from July 1980 to September 1983 were analyzed to estimate the percent reduction in the Medi-Cal per diem. To assess the impacts of contracting on expenditures, utilization, Medi-Cal recipients and hospitals, a one-week sample in January 1983 and 1984 of Medi-Cal inpatient and outpatient claims was analyzed. Annual hospital cost reports from the California Health Facility Commission were also used to supplement the analysis.

2. Children's Hospitals were later included in the contracting program after a study concluded that including Children's hospitals was feasible and potentially cost-effective.

slightly lower than average. Hospitals which were able to negotiate multiple rates--as opposed to the single all-inclusive rate preferred by the State--had the smallest rate decreases.

The net effect of these lower rates was a reduction in State expenditures for inpatient services. As Table V.4 shows, the State experienced about a 16 percent reduction in Medi-Cal expenditures for inpatient hospital services for all hospitals in the year following the start of selective contracting. Payments to contract hospitals decreased about 10 percent but they had an increase in the number of admissions (12.5 percent) that was more than twice as high as the overall average increase. Contract hospitals, thus, absorbed the patients who were previously treated at noncontract hospitals, which resulted in almost a 13 percent increase in admissions.

Given the decline in per diem rates and expenditures, it is not surprising that costs per admission also declined, but here the decline was no greater for the contract hospitals than for all hospitals (20-21 percent for both groups).

Because our patient samples were drawn in January of 1983 and 1984, when hospital admissions are higher than average, the appropriate way to estimate the savings due to Medi-Cal contracting is to use multivariate analysis to estimate the expenditures in 1984 using 1983 data.[1] This approach measures what costs in 1984 would have been if the contracting program was not in effect. The estimated 1984 payments can then be compared to the actual 1984 payments to arrive at a savings estimate. Application of this approach found

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1. Multivariate analysis also allows us to control for differences in hospital characteristics (peer group status, ownership, bed size, contract status, and occupancy rates) and patient characteristics (length of stay and diagnoses).

Table V.4

Medi-Cal Expenditure and Utilization Changes
Before and After Selective Contracting
(January 1983 and January 1984)

	Contract Hospitals (223)			Non-Contract Hospitals (265)		
	Pre	Post	Percent Change	Pre	Post	Percent Change
Inpatient Services:						
Inpatient Payments (in thousands)	$15,882	$14,358	-9.6%	$17,255	$14,580	-15.5%
Number of Inpatient Admissions	5,306	5,971	+12.5%	5,805	6,083	+4.8%
Average Length of Stay	5.3	5.1	-3.8%***	5.3	5.2	-1.9%***
Average Rate per Day	$ 584	$ 475	-18.7%***	$ 584	$ 472	-19.2%***
Average Rate per Admission	$ 3,019	$ 2,405	-20.3%***	$ 3,019	$ 2,397	-20.6%***
Outpatient Services:						
Outpatient Payments (in thousands)	$ 1,853	$ 1,991	+7.5%	$ 2,022	$ 2,110	+4.4%
Number of Outpatient Visits	32,063	36,884	+15.0%	34,633	39,017	+12.7%
Average Rate per Visit	$ 59	$ 54	-8.5%***	$ 59	$ 54	-8.5%***

NOTE: All dollars represent inflation-adjusted dollars as of January 1983.

***Differences for means between the pre- and post- periods are significant at the .01 level.

that annualized savings due to contracting were $175 million. Most of these savings were due to shifting patients to less expensive hospitals relative to 1983 utilization, both from non-contract to contract hospitals and among contract hospitals.[1] It must be noted that the approach for estimating these savings is very sensitive to the relationship between the deflator--a California hospital market basket index--and the rate of growth in per diem and per admission payments that would have occured without selective contracting. If the latter grew more slowly than the deflator, perhaps because of PPS and other factors affecting the hospital market, then this approach will overstate the savings due to selective contracting.

Despite the reduction in rates, hospitals could, in principle, circumvent these reductions by increasing the patient's length of stay. California's well-established utilization review process was expected to minimize this potential problem and preserve the expected savings. The data, in fact, suggest that the utilization review program did control any incentives for hospitals to increase the patients' length of stay. Overall, the average length of stay decreased slightly from 5.3 days in 1983 to 5.2 days in 1984.

Access and Quality of Care. There were three principal concerns about program impacts on recipients: (1) general difficulties in recipient access to care; (2) specific problems in the avoidance or transfer (often referred to as "dumping") of expensive cases; and (3) deterioration in the quality of care.

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1. Annualizing the simple difference between cost per admission in 1983 and 1984 multiplied by the January 1984 admissions predictably yields a higher savings estimate ($249 million).

Initial interviews conducted with advocacy groups, hospital staff, and State officials suggested that access was unchanged by contracting, given the State's early choice to contract with most major Medi-Cal providers. In addition, low occupancy rates in most California hospitals do not encourage the transfer of any patient that a hospital could legitimately keep. Further, State monitoring activities have not revealed evidence that access to care has been impaired or inappropriate transfers have occurred under contracting.[1]

Two quality of care indicators, transfer rates and fatality rates, are shown in Table V.5. Less than 1 percent of all patients were transferred to another acute care facility in either period. About 2 percent of all patients died within 30 days of admission in both time periods. Transfer rates increased substantially and significantly among noncontract hospitals, from less than 1 percent in 1983 to about 6 percent in 1984. This is consistent with selective contracting policy in which after a patient is stabilized, patients in noncontract hospitals are transferred to contract hospitals. There is a measured difference in fatality rates between contract and noncontract hospitals. But since it appears both before and after contracting it is not attributable to contracting per se; nor is it statistically significant at any commonly accepted level of significance, suggesting that it may simply reflect the problem of small samples.

Implications for other States. Implementation of selective contracting in California and Illinois did not require a large expenditure of new administrative money: only $1-$2 million per State. Nor did it require much time: a little over a year from the passage of authorizing legislation to the

1. California Department of Health Services, Selective Provider Contracting Program, Annual Report, July 1986.

Table V.5

Medi-Cal Patient Disposition, Before (1983) and After (1984) Selective Contracting

	Contract Hospitals		Noncontract Hospitals		All Hospitals	
	Pre	Post	Pre	Post	Pre	Post
Number of Admissions	(5542)	(6315)	(631)	(123)	(6173)	(6438)
Transferred to Other Acute Care Facility	0.52%	0.40%	0.48%	5.7%***	0.52%	0.50%
Died within 30 Days of Admission	1.82%	1.84%	3.32%	5.69%	2.0%	1.9%

***Difference between time periods is statistically significant at the .01 level.
**Difference between time periods is statistically significant at the .05 level.
*Difference between time periods is statistically significant at the .10 level.

implementation of inpatient reimbursement under contracting. However, there were other problems: it required special personnel—obtained outside the normal civil service system (at least in California)—working very hard under unusual grants of autonomy and discretion in both States. Had contracting been implemented more routinely—through existing agencies and personnel, under authority that provided less independence and room for maneuver—it would have been far more difficult. California and Illinois were able to grant-and maintain-these special terms of operation, largely, it seems, because contracting was established amidst real fiscal crises that disarmed for the time being the political opposition that normally qualifies the authority, and encumbers the operations, of such efforts. Other States might not be able to match these terms.

But to the degree other States can match what California and Illinois created, contracting does appear to provide a feasible and flexible means for controlling Medicaid inpatient costs, in the short run at least. Providers seem relatively satisfied with the arrangement, particularly in view of the inflexible rate-setting most providers imagine as the likely alternative to contracting. Providers report that they prefer contracting to other prospective rate-setting alternatives because it permits the State modestly to adjust the terms of reimbursement to the individual circumstances of each hospital. Contracting thus provides flexibility that cannot easily be established through centralized rate-setting schemes.

On the other hand, there are serious reasons for concern about how selective contracting will work over a longer time horizon. First, a system which establishes prices on an all-inclusive per diem basis creates incentives for hospitals to choose less costly cases. While not as serious as in a per

case system which did not adjust for case-mix, the California system is clearly not case-mix neutral. Second, it is not clear if the State could be as successful in obtaining low bids the next time around. Creating the conditions for success (e.g., many competitors, absence of collusion, realistic threat of exclusion, or severe financial penalties) may become more difficult to achieve. Third, hospitals may be less willing to bid low rates. In the first round, hospitals may bid at a rate approximating short-run average variable costs. But over a longer period, more costs are variable (e.g., decisions on staffing, wages, renovation) and hospitals may be unwilling to submit bids that will not cover a greater share of total costs. It may prefer instead to avoid Medicaid patients. Fourth, hospitals may adjust by eliminating special services which are monetarily unprofitable but nonetheless of value in the community (e.g., screening programs, indigent care.) Elimination of such services may bring pressure on the State to limit the impact of the bidding process.

One issue for further consideration concerns how much the selective contracting approach should rely on negotiation versus competitive bidding in selecting hospitals. The California and Illinois programs have relied on face to face negotiations between the State and the hospitals. This approach is probably excessively burdensome to all parties over the longer run and may eventually result in a situation where relative bargaining skill becomes an important consideration. The State and hospitals may benefit if selective contracting programs move toward a system of routine bidding via a sealed bid, thus easing the administrative burden. Furthermore, such a system will probably encourage hospitals to submit their most favorable price immediately (if the threat is realistic) rather than engage in the typical behavior of a

bargaining situation--where each party takes a position which they expect to move away from as negotiations progress, and a skillful bargainer may achieve a price for the hospital in excess of their efficient price.

What Is a DRG System?

Medicaid programs in eight States are now using a system of hospital reimbursement based on a Diagnosis Related Group (DRG) and two more will shortly implement such systems. The passage of OBRA made it easier for States to adopt a DRG system, and they were further encouraged to do so when Medicare embraced this concept with its Prospective Payment System (PPS) in 1984.

The essential feature of a DRG system is that a hospital is paid a rate per admission that is set in advance on the basis of a diagnosis. The payment per diagnosis is traditionally determined from a detailed study of hospital historical cost, and it is set to cover the average cost of the average admission with that diagnosis after adjusting for factors such as teaching status, rural location, and inflation. A hospital that is as efficient as its peers will profit on the cases which turn out to have lower than average costs and it will lose money on the cases with higher than average cost. On average atypically expensive and inexpensive cases should balance out.

From the perspective of Medicaid, or any other payer using a DRG system, the key feature of the system is that it penalizes those hospitals which have higher than average costs for reasons that apparently cannot be explained by anything other than inefficiency. Hospitals with costs above those of their peers will lose money under a DRG system while those with costs below their peers will profit. A DRG system thus sets up a strong incentive for inefficient hospitals to either improve their efficiency or to send unprofitable cases to a more efficient hospital.

The main drawback of a DRG system is that it contains an implicit reward for substandard care; a hospital can collect the full DRG payment even if it renders cursory treatment and makes an unusually quick discharge. For this reason, a program of case review by an independent party who is charged with discovering inappropriate care is intrinsic to a DRG system.

To determine more fully the experiences of Medicaid with DRG programs, this project undertook studies of the DRG systems in New Jersey and Pennsylvania. New Jersey was selected for study because of the State's early involvement in developing a DRG program; Pennsylvania was selected because it represented a typical situation of starting up a new DRG program. For New Jersey, we undertook an extensive case study followed up by a statistical analysis of hospital financial reports and patient claims, allowing assessment of the impacts of the DRG system in that State. Discussion of the estimated impacts in New Jersey follows our description of the New Jersey and Pennsylvania systems. For Pennsylvania, we conducted a case study to learn about the design of the system and its initial experience; the program is too recent to permit a statistical analysis to evaluate its outcome.

All Payer DRG Reimbursement in New Jersey. New Jersey currently operates under an all-payer hospital reimbursement system which was established in 1980 through State legislation and Medicare and Medicaid program waivers. The New Jersey DRG All-Payer System establishes payment rates for Medicaid, Medicare, Blue Cross, and private pay patients. Consequently, the State does not participate in the Medicare Prospective Payment System which is a generically similar program of diagnosis-based reimbursement. Since New Jersey has nearly four more years of experience with DRG reimbursement than does the PPS program, its experience may indicate some potential problems or advantages of the national Medicare system.

The current DRG all-Payer system replaces the Standard Hospital Rate Setting and Evaluation (SHARE) system instituted in 1976. SHARE was a prospective payment system which applied to Medicaid and Blue Cross only; Medicare reimbursed under its own national cost-based reimbursement rules while other private payers paid hospital charges. The New Jersey DRG system thus is innovative both in its use of diagnostic categories as a method of prospective reimbursement and in that all payers are bound together in a common rate-setting methodology.

Medicaid DRG Reimbursement in Pennsylvania. The Medicaid Prospective Payment System in Pennsylvania is a DRG-based hospital reimbursement program which operates independently from other payers. The system is generically similar to the DRG reimbursement approach of the Medicare Prospective Payment System. Unlike the New Jersey All-Payer Program, however, Pennsylvania Medicaid has not designed its program to pay for a portion of uncompensated care in hospitals. This State thus offers an example of a DRG system that is dedicated solely to the programmatic needs of Medicaid.

The Pennsylvania DRG system was implemented in July 1984 with provision for a two-year phase-in period where payments would depend upon a blend of the DRG rate and a hospital's own costs. The 1986-1987 fiscal year thus constitutes the first full year where reimbursement is fully determined by the DRG payment rate.

The purpose of the Pennsylvania program is to create incentives in the long run for greater economy in treating Medicaid patients. However, the program was designed to initially be reimbursement neutral to hospitals. That is, major program savings were not sought via the initial rate structure.

Early analyses of the program conducted by the State indicate that it has experienced a reduction in length of stay of approximately 16 percent. Further, there has been no appreciable rise in the rate of admissions per eligible (about 215 admissions per 1,000 eligible). There have been substantial increases (about 80 percent) in the percentage of discharges to rehabilitation/psychiatric/personal care homes and a decrease (7.5 percent) in discharges to nursing homes. There has also been a substantial (almost 85 percent) increase in the rate of readmission.

What Are the Impacts of the All-Payer DRG System in New Jersey?

An important feature of the New Jersey system is that the costs of uncompensated care are shared in the rates. That is, Medicaid and Medicare pay for a portion of a hospital's uncompensated care. This departs from the traditional rationale that Medicaid and Medicare have no "bad debts" of their own because they always pay their own bills. Philosophically, both programs now recognize that bad debts are part of a hospital's cost of being in business and, accordingly, pay for some of these costs.

An implication of this approach is that, at least in the short term, an all-payer DRG system may have rates which are higher those which might be obtained from systems of competitive contracting. In the latter systems, hospitals might be willing to quote bargain rates (i.e. marginal costs that do not cover any allocated overhead) in order to obtain Medicaid business. In New Jersey, the Medicaid program is committed to paying its fair share of bad debt. An additional feature of a DRG system is that its rates are based upon the average cost experience of hospitals in various peer groups. Average costs are not, by definition, the costs of the least expensive hospitals.

Again, by implication, a DRG system may be expected to be more costly to the Medicaid program than would a system of selective contracting which successfully elicits the best price that bidders have to offer.

This expectation, of course, depends on several critical assumptions about how the alternative systems work out over time. For example, it assumes that the bidding process continues to be successful in eliciting the lowest possible price (gaming, collusion, etc., are absent), and that the DRG system is not successful in ratcheting down on rates to reap the savings from lower hospital costs.

The all-payer DRG program in New Jersey decreased the real cost of Medicaid hospital care on both a per day and per admission basis. Average length of stay also fell over this period. All of these outcomes resulted in lower total hospital expenditures for the New Jersey Medicaid program after adjusting for general inflation. However, admission rates rose under the DRG program even though the number of Medicaid eligibles fell.

It appears likely that the reimbursement rules of the DRG program were at least partly responsible for increasing the number of admissions, whereas the decrease in the number of Medicaid eligibles was almost certainly due to changes in program rules which were independent of the DRG program. The net result is that the New Jersey DRG program would have cost more than the previous program had it not been for a fortuitous decrease in the number of Medicaid eligibles. The ability of a DRG program to control admissions

therefore becomes an important consideration in evaluating its utility as a cost containment program.

Table V.6 presents basic utilization and expenditure data for New Jersey in 1979 and 1983. The table is based upon the cost reports of 54 general hospitals which filed reports in both years. The years are chosen because they offered the largest number of comparable cost reports for hospitals in the State. (Recall that 1979 represents the last year of operation under the SHARE reimbursement program; 1983 represents the first year all hospitals were under the DRG program.) While the sample is not random and caution should be used when drawing inferences, inspection of the sample reveals no anomalies in the proportions of hospitals which are represented by size and location. All dollar figures are in inflation-adjusted 1979 dollars (deflated by the GNP Implicit Price Deflator, however, not by the Medicaid-specific price index).

During the 1979-1983 period, the number of Medicaid eligibles fell by 12 percent, from 625,268 to 549,356. The fall in the number of eligibles was almost certainly due to factors outside of the control of the Medicaid hospital reimbursement program--namely the changes in eligibility instituted by OBRA and TEFRA discussed in Chapters III and IV of this report.

Average Medicaid hospital expenditures for this sample of hospitals fell by 6.6 percent from $1,959,492 in 1979 to $1,829,891 in 1983, representing a drop in Medicaid expenditures per admission from $1,642 to $1,360. This occurred because of a drop in the Medicaid length of stay from 6.7 to 5.7 days; cost per day changed very little.

The Medicaid eligibility constraints instituted in the early 1980s should mean that the remaining Medicaid population consists of people with worse

Table V.6

Medicaid Expenditure and Utilization
in New Jersey, 1979 and 1983

(All dollars are 1979 equivalents)

	1979	1983	Percent Change
Total Eligibles	625,268	549,356	-12.1
Hospital Average:			
Medicaid Expenditures	$1,959,492	$1,829,891	-6.6
Admissions	1,152	1,335	15.9
Patient Days	7,454	7,172	-3.7
Expenditure/Admission	$1,642	$1,360	-17.2
Expenditure/Day	$244	$235	-3.7
Length of Stay	6.7	5.7	-14.9

Source: Authors' computations based upon State of New Jersey, Department of Human Services, Medicaid Annual Report (1979, 1983) and Payer Summary Report.

health status, given that the working poor were most likely to lose eligibility, and they average better health than other Medicaid recipients. This suggests that the rate of hospital admission per thousand eligibles should increase but that the absolute number of admissions should decline due to the smaller number of eligibles. In our sample of New Jersey hospitals, on the contrary, the absolute number of Medicaid hospital admissions rose. This means that the number of admissions per thousand eligibles increased following implementation of the DRG program, perhaps due to increased admissions of low-cost cases or to increased readmissions. A confounding factor is that the systems which preceded the DRG system (SHARE) incorporated a Medicaid discount; with the DRG system, Medicaid paid the same as other payers. The average number of admissions per year increased in our sample of hospitals from 1,152 to 1,335 in spite of the decrease in the number of eligibles. This 15.9 percent rise in Medicaid admissions outstripped the 9.5 percent rise in all New Jersey hospital admissions during the same period.

The implication of these changes is that the DRG program had considerable success in achieving economies in hospital expenditures per admission but these may have been offset by higher admission rates. Indeed, if the number of eligibles in 1983 had been the same as in 1979, program expenditures would have risen by 6 percent instead of falling as they did by nearly 7 percent. One possible explanation for the higher admission rate is that hospitals became less concerned about screening patients for their ability to pay as a result of the all payer system. A hospital's bad debts essentially became a

liability to other third-party payers rather than to the hospital itself.[1] The all payer DRG program in New Jersey thus raises questions about the side effects of such a program on admissions, especially admissions of the indigent. States which undertake to design and adopt Medicaid DRG programs should carefully consider the issue of whether their program should bear a share of bad debt. Rather surprisingly, New Jersey illustrates that a Medicaid program can achieve lower unit costs even after assuming responsibility for some part of bad debts.

One issue of concern with respect to DRG systems is the incentive to either change practice patterns or to change claims coding procedures (commonly called DRG creep), in order to maximize reimbursement. Our analysis was based on samples of New Jersey Medicaid claims for 1979 and 1983. DRG data for 1979 were developed by the State of New Jersey by recoding claims to determine what the appropriate DRG would have been if the program had operated that year.

Overall, our analysis indicated that hospitals responded to the initiation of DRG payments in a manner consistent with predictions of how such a system would influence behavior. Hospitals tended to specialize in those cases where their costs compared favorably to DRG payment rates--that is, they

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1. One caveat in regard to data should be raised here. The admission figures which we use come from hospital cost reports (SHARE forms). Admissions by type of payer are reported by hospitals based upon their best guess at the time of admission of the eventual source of payment. Not all cases initially classified as Medicaid may turn out to be correct. If hospitals became more willing to admit cases with dubious payment capability, and if hospitals tended to classify dubious cases as Medicaid, the Medicaid admission figures for 1983 will be overstated compared to final audited admissions. However, any overstatement continues to illustrate the point that the all payer system created an incentive for hospitals to be less careful about screening for financial status prior to admission.

tended to increase their caseloads where the reimbursement rate was higher than their average costs and to decrease caseloads where reimbursement was low relative to cost.[1] In addition, following adoption of the DRG program, hospitals gave greater attention to coding complications and comorbidities than they did under the prior system where no financial importance was attached to this information.

Finally, there was a clear change in the mix of Medicaid cases between 1979 and 1983, presumably due to changes in program eligibility. The change in casemix was away from cardiac and gastrointestinal problems and toward gynecological and childbearing conditions. This appears to reflect the contraction of eligibility toward the non-working-poor core group of persons eligible for Aid to Families with Dependent Children.

Summary

This chapter has focused on State Medicaid policies toward hospital payment. States have been faced with unique opportunities offered by OBRA and subsequent federal actions to control a major component (about 1/4) of their Medicaid expenditures through use of reimbursement systems with stronger incentives for cost control. They have responded rapidly to these opportunities. Compared to where they were in 1981, 30 States had significantly changed their Medicaid hospital payment programs by 1985. The trend was to base payment upon some standard external to the individual hospital

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1. It should be noted that a system like selective contracting, where hospitals bid a simple price that is to cover, on average, all diagnoses, has potentially stronger incentives to select low-cost cases, because it makes no allowance for high-cost conditions.

such as the average costs of peer hospitals, trends in input prices, or the industry average costs of treating a particular diagnosis.

The movement toward new payment systems was paralleled by a reduction in the rate of increase in Medicaid hospital expenditures nationwide. States which initiated alternative reimbursement programs had lower rates of hospital expenditure growth than did States which made no changes in their programs. For the period 1981-1984, States using traditional Medicare reimbursement systems had an average annual growth in expenditures of 8.7 percent (down from 15.6 percent for the period 1978-1981). Pre-OBRA rate setting States averaged an increase of 7.2 percent (down from 14.1 percent), while post-OBRA rate setting states averaged an increase of 6.6 percent (down from 14.9 percent).

When rate-setting systems were separated into Medicaid-only, some (but not all) payer, and all-payer systems, it was found that the Medicaid-only and all-payer systems both had significant cost-containment effects. Statistically significant reductions in hospital spending from 1977 to 1984 were found for all-payers to be 6.1 percent per year and from Medicaid-only to be 7.6 percent per year. However, the effect of the Medicaid-only systems was confined to the first full year of operation. The effect of the all-payer systems continued throughout the observation period.

Among the alternative reimbursement approaches taken by the States, two methods appeared to be particularly innovative: selective contracting, and DRG-based systems. Selective contracting is the most dramatic departure from the traditional hospital payment methods, essentially a variant of competitive bidding. The DRG system which was adopted for the Medicare program is being increasingly implemented by State Medicaid programs. Both of these approaches were studied in detail by this project.

Selective contracting forces hospitals to take the initiative in discovering how to lower their costs and to pass on to the State (at least some of) these savings via a relatively low bid. The focus of pricing shifts from simply limiting the annual rate of inflation to one of justifying the hospital's level of prices relative to its competitors. California was chosen for our impact evaluation because it was the first system to be implemented. (Illinois system is too recent for systematic evaluation).

California's experience with selective contracting so far has been encouraging. It has led to lower payment rates without apparent problems in quality of service, or adverse practice patterns. The State experienced about a 16 percent reduction in Medi-Cal expenditures for inpatient hospital services for all hospitals in the year following the start of Selective Contracting. Further, State monitoring activities have not revealed evidence that access to care has been impaired or inappropriate transfers have occurred under contracting.

There are important caveats about the generalizability of this short term experience. First, California may have been successful in part because of its many high-cost/low-occupancy rate hospitals; the conditions for success may become more difficult to achieve in subsequent negotiations. Hospitals may also bid higher rates over time as more of their costs become variable costs (as new decisions on staffing, wages, renovation, etc., must be made). This may lead to a higher proportion of hospitals becoming prepared not to treat Medicaid patients.

Medicaid programs in eight States are now using a system of hospital reimbursement based on Diagnosis Related Group (DRG) and two more will shortly implement such systems. The passage of OBRA made it easier for States to

adopt a DRG system, and they were further encouraged to do so when Medicare embraced this concept with its Prospective Payment System (PPS) in 1984. The theoretical attraction of DRG systems is that, by fixing rates at average operating costs, they stimulate efficiency increases thorugh the promise of "profiting" by any favorable costs differential between the "average" rate and its own costs. New Jersey was selected for our impact evaluation because it was one of the earliest to be implemented.

The all-payer DRG system in New Jersey reduced the real costs of Medicaid hospital care on both a per day (down 3.7 percent from 1979 to 1983) and per admission (down 17.2 percent) basis. Admission rates rose (up 15.9 percent), however, counteracting the unit cost savings.

This study could not determine whether selective contracting systems or DRG systems are likely to be more effective. Which system is more successful in containing costs depends on how successful selective contracting systems are in obtianing low prices in subsequent bidding efforts versus how aggressive DRG systems are in capturing the efficiencies generated by a price system. And any system will have limited effectiveness over the long run unless other payers impose similar restraints.

Selective contracting is administratively less burdensome than a DRG system in that states can ask for bids in the form of an all-inclusive per diem rate, rather than having to continuously fine tune and periodically revise rates and reimbursement rules. But the negotiation phase in the currently operating selective contracting system is burdensome on all parties and may result in a situation where relative bargaining still becomes an important determinant of the outcome. A system of routine bidding via a sealed bid would certainly ease the administrative burden, and might result in improved prices for Medicaid.

VI. CASE MANAGEMENT UNDER FREEDOM-OF-CHOICE WAIVERS

OBRA 1981 gave States the opportunity to obtain waivers to loosen recipient "freedom of choice" restrictions. The principal purpose of these waivers was to establish primary care case management (PCCM) programs with the dual objectives of containing costs and improving service access, coordination, and quality. In this respect, PCCMs are more oriented to improving the delivery system than many cost-saving changes stimulated simply by rising medical care costs and redefined Federal participation. They also carry the risks of relegating Medicaid recipients to second-tier medical care, an outcome that the original freedom-of-choice concept sought to avoid.

Very briefly, under PCCM Medicaid recipients select (or are assigned) a primary care physician or other primary care provider, who becomes their medical case manager. Thereafter, except in a true emergency, all care must be provided or authorized in advance by the case managing physician.

Over the past five years, many States have taken advantage of the PCCM opportunity. Some States choose to apply PCCM under the conventional fee-for-service (FFS) approach while others used the new flexibility in freedom of choice to expand the use of health maintenance organizations (HMOs) and other

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This chapter summarizes findings presented in Lawrence Bartlett et al., "A Descriptive Analysis of States' Responses to the Provisions of Section 2175 of P.L. 97-35, The 1981 Omnibus Budget Reconciliation Act," MPE Working Paper 4.1; James Bell et al., "Primary Care Case Management in Medicaid: Findings from Six Case Studies," MPE Working Paper 4.5; James Bell, Helen Rosenthal, and Larry Beyna, "Michigan's Physician Primary Sponsor Plan: Implementing Primary Care Case Management in Medicaid," MPE Working Paper 4.2; Helen Rosenthal, Larry Beyna, and James Bell, "Utah's Choice of Health Care Delivery: Implementing Primary Care Case Management in Medicaid," MPE Working Paper 4.3; and Susan Kessler Beck and Mary Ann McCanna, "Primary Care Case Management in Medicaid: Case Studies of Four State Programs," MPE Working Paper 4.4.

prepaid arrangements. Still other states applied PCCM to both FFS and HMOs as an experiment to access the relative effectiveness of PCCM under different reimbursement approaches. In order to evaluate the effects of their experience, we tracked all of the Medicaid PCCM programs through September 1986 and undertook six case studies of PCCM programs that had had enough implementation experience to allow an initial assessment of impact.

This chapter describes our findings with respect to the following questions about PCCM design, implementation and effects:

1. Why did the states adopt the PCCM approach? What conditions encouraged states to consider PCCM and what objectives were PCCMs expected to meet?

2. How are PCCM systems designed? Which recipients and services are covered by PCCM? What are the reimbursement arrangements? What must providers, recipients and administrators do differently to make PCCM works?

3. How were PCCMs implemented? How did state Medicaid officials gain approval of their PCCM plans? How were providers and enrollees recruited for PCCM participation? What kinds of problems were experienced during implementation?

4. How have recipients and providers responded to PCCM? How successful have PCCMs been with respect to recipient and provider enrollment?

5. What is the impact of PCCM? To date how has PCCM affected access to services, the quality of services, and Medicaid program costs?

6. What can other states learn from PCCM experience to date?

Data and Methodology

Information from HCFA and the States on the experience with PCCM waivers was compiled to create an inventory of new programs and their characteristics. Besides generally informing interested parties about the States' responses to flexibility in the area of freedom of choice, the inventory helped in selecting case study programs. By early 1984 it was clear that States were strongly interested in PCCMs and that two PCCMs had been in operation long enough to warrant a detailed assessment: Michigan's Primary

Physician Sponsor Plan (PPSP) and Utah's Choice of Health Care Delivery program (CHCD). We began our studies with in-depth case studies of these two PCCM programs and have tracked their progress for three years.

Other PCCM programs had already begun or were in the final planning stage and, by the third year of our study, several had matured to a level and size at which a review would yield useful information. Therefore, four of these newer PCCMs were examined: Kansas's Primary Care Network (PCN), Colorado's Primary Care Physician Program (PCPP), Nevada's Primary Care Case Management program (PCCM), and Wisconsin's HMO-Preferred Enrollment Initiative (PEI). These four programs were chosen with Michigan's PPSP and Utah's CHCD, for the following reasons: (1) they are, with the exception of Nevada's program, among the largest in the nation, in terms of recipients enrolled; (2) they have the longest period of operation; and (3) they cover a variety of PCCM system characteristics, such as, mandatory and voluntary enrollment, statewide and non-statewide implementation, and fee-for-service and capitated reimbursement.

While the Michigan and Utah case studies were more extensive than the others, all six studies included the following: (1) detailed examination of available documentation, such as waiver and waiver extension requests, progress reports, provider agreements, brochures, etc.; (2) frequent telephone discussions with State Medicaid officials; (3) site visits, including observations of the PCCM in operation, and discussions with administrators, providers, recipients, medical society officials, and legislators; (4) analysis of available data on program processes, such as recipient and provider enrollment; and (5) secondary analysis of States' studies of program effects, such as changes in expenditures, access and quality.

Every effort has been made in these studies to examine the data critically, however, our findings are constrained by the availability and quality of data and analyses generated by the States, especially in the area of impact. For example, since freedom-of-choice waivers became available in 1981, the State findings may be influenced by the need to show savings from their case management programs to HCFA in order to continue under waiver. Combined with the newness of the programs and the absence of well-tested methods for analyzing outcomes like expenditure change and recipient satisfaction, this means that despite our critical review of the data, the States' findings presented herein should be viewed with caution.

What is Recipient Freedom of Choice and Why Is OBRA 1981 Significant?

Until the Omnibus Budget Reconciliation Act, 1981, freedom of choice of provider had been an almost inviolable tenet of Medicaid policy. Under freedom of choice, Medicaid recipients were allowed to obtain services from any qualified provider willing to serve them and State Medicaid programs could only restrict that right in exceptional cases, such as documented excessive use of prescription drugs. It was felt that freedom of choice was a necessary safeguard against developing a two-tiered medical service delivery system: one level of access and quality for those who could afford coverage and another, lower, level for those who needed Medicaid assistance.

Although freedom of choice did provide Medicaid recipients a measure of protection against discrimination in the health care system, it by no means guaranteed equal access and treatment. Freedom of choice could not influence providers to serve Medicaid recipients, and many chose not to do so because of such powerful disincentives as low reimbursement rates and high paperwork

requirements. Furthermore, freedom of choice made State Medicaid programs vulnerable to such costly problems as doctor shopping and inappropriate use of emergency room services. Under freedom of choice, recipients had the right to change doctors, and many did for good reason. Some recipients, however, changed doctors frequently, thus requiring Medicaid to pay for duplicative diagnostic tests and consultations.

As a result of insufficient provider participation, recipient doctor shopping, and other problems with the system, many recipients failed to establish a "medical home" with any one provider who could become familiar with their case and treat them over the long term. Ironically, then, freedom of choice seemed to be related to ineffective and unnecessarily expensive care patterns.

In the 1970s, as the costs of health care climbed, many State Medicaid programs began seeking and using new means of controlling costs. In addition to adjusting eligibility, service coverage, and reimbursement rates, they were seeking other mechanisms to contain costs without hindering access or quality. Many States saw the freedom-of-choice requirement as a crucial limit on their flexibility to control excessive and inappropriate use of services and wanted to experiment with managed health care approaches.

In 1981, Congress relaxed the freedom-of-choice requirement. Partly as a concession to the States in exchange for other, more dramatic, Federal constraints on the Medicaid program, Congress authorized, under OBRA Section 2175, two general types of exceptions to the freedom-of-choice requirements:

(1) States would no longer be out of compliance with Federal requirements if they:

    (a) purchased laboratory, x-ray services, or medical devices through a competitive bidding process or other means,

(b) established a "lock-in" program which restricts for a reasonable period of time the choice of provider by a recipient who has overutilized services, or

(c) established a "lock-out" program which limits the Medicaid participation of a provider who has abused the program.

(2) States could be exempted from the freedom-of-choice requirement by obtaining a waiver from the Secretary of Health and Human Services under new section 1915(b) of the Social Security Act. These waivers could be obtained to:

(a) implement a primary care case management system or a specialty physician services arrangement;

(b) allow a locality to act as a central broker in assisting Medicaid recipients in selecting among competing health care plans;

(c) share with recipients, through the provision of additional services, the savings from recipients' use of more cost-effective medical care; or

(d) restrict recipients to receiving services (other than in emergency situations) from only efficient and cost-effective providers.

What Was the States' Response to OBRA Flexibility?[1]

Although the new flexibility stimulated both waiver and non-waiver freedom-of-choice initiatives, the bulk of the States' response centered on waiver initiatives. By September 30, 1986, 32 States had submitted 125 waiver requests for 82 different programs. (Modifications and renewals are not included.) Of these requests, HCFA had approved almost half and 29 were still pending. Of the approved waivers, about three-quarters were implemented and

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1. Much of the information in this section is taken from Lawrence Bartlett et al., MPE Working Paper 4.1, which provides a description of non-waiver freedom-of-choice initiatives (such as recipient lock-in, provider lock-out, and volume purchasing) as well as the PCCM program, which are the focus in this chapter.

over half were still in force in late 1986. Five had been terminated by the States, and 7 had expired and not been renewed. Table VI.1 summarizes the data on all freedom-of-choice waivers between OBRA passage and September 1986.

Primary care case management (PCCM) programs for basic medical care are the most common type of waiver program. Others include selective contracting, mental health service, dental service, and pre-natal service programs. About two-thirds of the total waiver requests were devoted to PCCM programs and about 60 percent of those were approved. (Note that many PCCM programs required two or more of the four kinds of waivers available, not just the 1915(b)(1) waiver allowing PCCMs.)

In late 1986, 25 waivers supporting PCCM programs were still in force. These active waivers involved a total of 16 primary care case management programs in 14 States. The pending case management waiver requests involved 10 new programs, 7 of them in States that did not have waiver programs at that time. The map in Figure VI.1 identifies all the States which, in late 1986, had active PCCM programs and/or one or more of the other three waiver types.

What Were the Objectives and Characteristics of PCCMs?

The PCCM we reviewed had common objectives that address key cost, access, and quality concerns. They were primarily intended to contain Medicaid expenditures, but in a way that would yield other positive outcomes as well. This would be accomplished by addressing important structural and behavioral problems at the service delivery level--problems of inadequate access to services and inappropriate use of services--which increase costs either in the short run or in the long run. PCCMs were seen as a way of dealing with a whole set of interrelated problems and, by so doing, ultimately lowering

Table VI.1

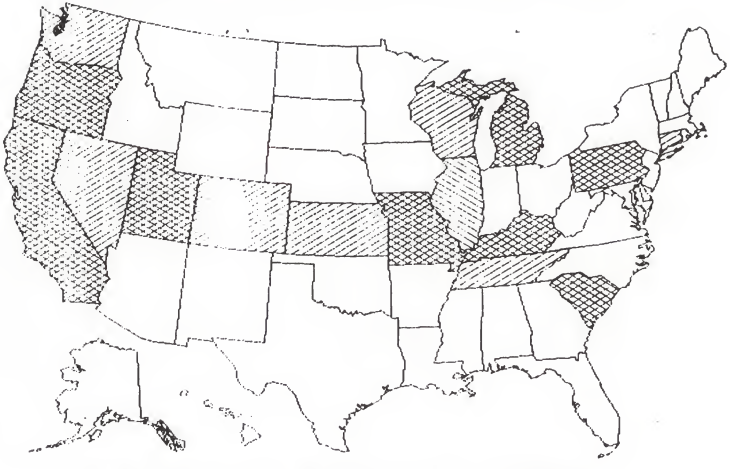
Freedom-of-Choice [1915(b)] Waivers Through September 1986

Type of 1915(b) Waiver	Requested		Approved		Implemented		Still Being Implemented[a]	
	Number	States	Number	States	Number	States	Number	States
(1) PCCM program or specialty physician services arrangement	55	24	31	18	23	15	18	14
(2) Locality acting as a central broker for recipients selecting health plans	3	3	2	2	1	1	1	1
(3) Shared savings with recipients	18	14	8	7	7	6	4	4
(4) Restriction of recipients to efficient providers only	42	19	18	12	13	11	9	8
No specific 1915(b) provisions	7	6	0	0	0	0	0	0
All	125	32[b]	59	20[b]	44	17[b]	32[c]	15[b]

SOURCE: Table from Bell et al., MPE Working Paper 4.5. Data originally from Bartlett et al., MPE Working Paper 4.1.

a. As of September 1986.
b. Unduplicated count.
c. Twenty-five of these waivers were devoted to 16 PCCM programs in 14 States.

FIGURE VI.1
STATE MEDICAID PROGRAMS WITH ACTIVE
FREEDOM-OF-CHOICE WAIVERS (September, 1986)


1915 (b)(1) Waivers (Case Management)
One or More of 1915 (b) (2,3, or 4) Waivers (locality as central broker, shared savings, efficient providers)
Both

Source: Beyna et al., MPE Working Paper 4.5.
Data originally from Bartlett et al., MPE Working Paper 4.1.

program expenditures. In addition to containing costs, the PCCMs were expected to:

- o increase provider participation in Medicaid and improve recipient access to mainstream care, primarily through providing the structure for more effective and satisfying physician-patient relationships and/or providing a monetary incentive to accept Medicaid patients;
- o provide recipients with continuous, regular care under one physician, through linking each recipient with a specific primary care provider, who manages all care and referrals, and discouraging provider changes without good reason; and
- o reduce inappropriate and excessive use, primarily through imposing strict referral and emergency room controls.

As one Medicaid official put it, even if PCCM were found not to save any Medicaid dollars, it would still be considered a success if it improved access and quality of care, two very important goals in the Medicaid program.

PCCM Eligibility. All six of the case study PCCMs included non-institutionalized AFDC eligible Medicaid recipients, and five (all except Wisconsin's PEI) included non-institutionalized SSI recipients. Two PCCMs--Nevada's and Colorado's--included some AFDC and SSI eligible institutionalized recipients, but the actual numbers of institutionalized enrollees were very small, particularly in Nevada's voluntary program.

While PCCMs generally serve non institutionalized AFDC and SSI eligibles, each of the six case study PCCMs has some exclusions. Exclusions by one or more of the six case study States are children in foster care or adoption support, crippled children, Medicaid-Medicare dual eligibles, SSI non-cash recipients, SSI blind and disabled (Nevada only), protective custody recipients, lock-in recipients, and HMO enrollees (where the HMO was not part

of the PCCM program). For the most part, these groups represented a small percentage of the total non-institutionalized Medicaid eligible population.

The experience of several States suggests that, where cost containment is the primary goal for case management, careful targeting of PCCM eligibility on those groups likely to yield the greatest savings is an important strategy. There is a trade-off, however, between the savings that targeting yields and the additional administrative and political costs it involves. Several States reported excluding certain groups for administrative convenience. For example, foster children were commonly excluded because their mobility creates administrative problems, such as the need to change providers on a frequent basis.

There are other considerations besides potential savings and administrative convenience in PCCM targeting. For example, when designing its PCCM, Nevada seriously considered excluding children. It was believed that children accounted for very little of the excessive and inappropriate use of services that PCCM was designed to reduce, and that children's care was fairly well managed without formal case management. Experience in Michigan, however, suggests that children should be included because case management appears to enhance the overall care they receive. Children in Michigan received more rather than fewer services under case management--suggesting that they probably should have been receiving these services all along.

Services Covered Under PCCMs. The kind of case management we found is best characterized as "gatekeeping," rather than in-depth medical case management with, for example, protocols for common diagnoses and preventive care or standards for referral. As such, primary care physicians (PCPs) typically provided their patients with the majority of needed primary care and formally referred them to specialists or authorized other care on an as-needed

basis. The PCCMs with the broadest service coverage are Nevada's and Wisconsin's, which are, respectively, partially capitated and almost fully capitated programs.

Most mandatory acute care services are covered under PCCMs. All of the case study PCCMs covered the following mandatory services: inpatient hospital, outpatient hospital and clinic (including ER), rural health clinic, laboratory and x-ray, temporary skilled nursing facility (SNF), and physician services. As for the other mandatory services, four of the six covered EPSDT (Early Periodic Screening, Diagnosis, and Treatment) screening, five covered EPSDT screening and treatment, and three covered family planning services. In short, most mandatory Medicaid services were governed by case management.

Among the major optional services provided under Medicaid, prescription drugs, physical and occupational therapy, and temporary intermediate care facility services were covered by all six PCCMs. Dental services, which were provided in all six study States, were managed under two PCCMs, podiatric under two (out of a possible five), optometric under four (out of a possible six), and chiropractic under two (out of a possible four).

Reimbursement Approach. The six PCCMs that were examined used a range of reimbursement approaches, and several included alternatives instead of a single approach. The variation among PCCMs involved two dimensions: fee for service (FFS) vs. capitation, and the presence or absence of an additional case management fee or other payment in the FFS models. In all the case study States except Kansas, capitation was either an integral part of or an available alternative to the PCCM program.

The PCCMs in four case study States used FFS-reimbursed case managers: Michigan, Utah, Kansas, and Colorado. Two of those four, Michigan and Kansas,

paid a case management fee of $3.00 per month per enrollee, and one, Colorado, paid its physicians a variable semiannual "incentive" payment. Utah's CHCD did not reimburse its FFS primary care physicians beyond the standard Medicaid rates for medical services rendered. Officials in the States with case management fees considered them necessary to secure the participation of primary care physicians in the case management program. Physicians were already dissatisfied with low reimbursement rates and were not considered likely to assume the additional responsibility of case management without additional compensation. Conversely, monthly management fees made Medicaid more attractive to providers by selectively raising reimbursements.

In designing Colorado's PCCM, Medicaid officials chose to avoid a set case management fee, but to promise participating physicians a share of whatever savings the program would yield. The physician incentive payment, or PIP, was thus a controlled expense, which could vary with the level of annual PCCM savings over the standard FFS expenditures for comparable recipient groups. The case management fee or incentive payment, in addition to attracting physician participation, may have encouraged some primary care physicians to take their case management responsibilities more seriously.

With respect to financial risk, the FFS primary care physicians in the Michigan, Utah, Kansas, and Colorado PCCMs were under no risk like other physicians in those States' Medicaid programs. In Wisconsin and Nevada, however, care was provided under risk-based arrangements in HMOs and the University of Nevada School of Medicine, and thus presumably the physician's treatment patterns were scrutinized more than in the others.

How Did Providers Respond to PCCM?

In spite of generally negative attitudes toward Medicaid, physicians were positive toward the PCCM concept. In their view, PCCM would provide more control over recipient utilization, more coordination of services and better physician-patient relationships.

The six major primary care specialties are general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics and general surgery. All the PCCMs targeted at least five of these, but several allowed exceptions. In deciding who would serve as primary care physicians, the States had to balance the advantages and disadvantages of restricting case management to primary care specialists. On the positive side, primary care specialists are typically more oriented toward treating the whole person, providing more patient education, and emphasizing preventive medicine more than other specialists. On the negative side, exclusion of non-primary specialists could encourage some to drop out of Medicaid entirely, which could result in the dislocation of some patients already seeing a specialist on a routine basis.

The strength and specificity of provider agreements varied, but Medicaid monitoring and enforcement of these agreements was generally weak. The type of agreement between Medicaid and providers ranged from a loose statement of intent to be a primary care case manager (e.g., Utah) to a detailed contract outlining Medicaid and provider responsibilities (e.g., Michigan). Several contracts provided for utilization review and sanctions for physicians whose patients overutilize services. In actual practice, however, these mechanisms were not even developed in several States and very rarely used in others.

All six PCCM contracts/agreements required that physicians provide 24-hour access to care, prior authorization of certain services and referral for specialist services. These three responsibilities, plus that of directly providing enrollees the major share of their primary care (which was explicitly stated in three documents and implied in the others) constituted the critical caregiving and gatekeeping function of the PCCM case manager. The 24-hour access requirement was important not only for continuity of care but also for deterring inappropriate emergency room utilization.

For the most part, those primary care physicians who joined the mandatory PCCMs did so early and quickly; enrollment was slower in the non-mandatory PCCMs. Where there was not fast and full enrollment of a critical mass of primary care physicians, overall PCCM implementation suffered. Recipient enrollment could not be done until physician case managers were available. As well, slow and incomplete physician participation increased the dislocation of enrollees who wanted to remain with the physician they had been using prior to PCCM.

The number of physicians enrolled in PCCMs did not meet initial expectations. For example, after 26 months, Michigan's PPSP enrolled only 37 percent of Wayne County Medicaid primary care physicians. Kansas's PCN, a mandatory program, was able to enroll 57 percent of the Medicaid-registered primary care physicians in the affected counties. Enrollment data for Wisconsin are ambiguous, because many physicians joined more than one HMO, thus inflating the total for all the HMOs combined.

Actually, basing PCCM enrollment figures on the number of physicians who had already been registered with Medicaid prior to implementation tends to understate physicians' willingness to join. Many physicians were registered,

but were not actually serving Medicaid recipients at the time, so in effect, their participation in Medicaid was dormant. Their non-enrollment in PCCM was inconsequential, except for the fact that their names were not put on the list for enrolling recipients to choose from. Many of these physicians were not opposed to PCCM; they just had no practical reason or need to join. When some did obtain patients who wanted them to become PCCM physicians, most joined with no objection.

In contrast to original expectations, there was little evidence that PCCMs attracted many additional primary care physicians to enroll in Medicaid. There was also no evidence that there were insufficient primary care physicians participating in PCCMs to meet enrollee needs at current levels of recipient participation. However, the small changes that did occur in the Medicaid primary care specialist pool reportedly had some repercussions for the pool of other specialists who served Medicaid patients. It is only natural that, in cases where their Medicaid patients have no preferences, primary care physicians will refer them to specialists whom they know and trust. In effect, some specialists were closed out of Medicaid when their primary care colleagues did not join the PCCM.

Medicaid caseloads did not appear to be consolidating under fewer primary care physicians in PCCMs. In the few States for which we have data, the average Medicaid caseloads for primary care physicians were 40.4, 50.6, and 126, in Colorado, Michigan and Kansas, respectively. All were well within the upper limit of 1,500 set by a few PCCMs.

Available evidence indicates that physicians were generally pleased with PCCM as implemented in their areas. Once physicians had enrolled, they had few problems with PCCM, and few disenrolled. Post-implementation attitudes

and perceptions are another indicator of satisfaction. With a few exceptions, the small number of physicians who were interviewed felt that PCCM was fair, working well, reducing enrollee utilization of services, and providing improved care for many enrollees. Although there were problems in each State, it was clear that PCCM had represented only a modest change in patient management for most physicians.

How Did Recipients Respond to PCCM?

In some PCCMs, recipient enrollment lagged far behind the target level. Prior to implementation of their PCCMs, the six case study States established targets for enrolling eligible Medicaid recipients. In all the States except Utah and Colorado, these targets were limited to a specific geographical area within the State. Although Utah began its CHCD in only four of its 29 counties, its target from the very beginning was statewide implementation; and Colorado planned and essentially completed statewide implementation in several stages. As Table VI.2 shows, the number of targeted eligible recipients ranged widely, from 5,000 in Nevada's two urban areas (Reno and Las Vegas) to 286,000 in Michigan's Wayne County (Detroit).

Table VI.2 also shows that the six PCCMs varied considerably in their success in meeting original enrollment targets. Alongside the initial target for each state, two sets of enrollment figures are presented. The first set includes the approximate number of enrollees reached prior to a major leveling off, after which only small gains or losses were recorded over time. It also specifies the percentage of the target that was achieved and the number of months it took. The second set includes the number of enrollees according to our most recent data, the percentage of target and the number of months since initial implementation.

Table VI.2

PCCM Recipient Enrollment Performance

	Michigan	Utah	Kansas	Colorado	Nevada	Wisconsin
Number of Enrollees Initially Targetted	286,448	50,477	22,800(a)	97,431	5,000	111,800(a)
Leveling Off Point:						
Number of months since implementation	(b)	(c)	6	19	(b)	11
Number of enrollees	(b)	(c)	22,798	77,974	(b)	111,796
Enrollees as a percent of targeted	(b)	(c)	100%	80%	(b)	100%
Most Recent Data:						
Number of months since implementation	42	36	23	45	36	16
Number of enrollees	82,000	34,743	72,000	78,000	2,600	120,407
Enrollees as a percent of targeted	29%	69%	100%	80%	52%	100%

SOURCE: Bell et al., MPE Working Paper 4.5. Data originally from various State documents.

(a) This is an estimated original target by both States. Both States later exceeded the initial target. In Kansas the PCCM was expanded to include more counties and in Wisconsin in the original target area the number of eligibles increased.

(b) A leveling point had not yet been reached at the point of most recent available data.

(c) It is not clear when enrollment leveled off.

Three major factors appear to have affected enrollment success:

Whether the program was mandatory or not. Kansas and Wisconsin--the two most decidedly mandatory programs, both on paper and in fact--were the most successful with enrollment. Almost all their targeted enrollees were enrolled within the first year.

The enrollment process. In general, enrollment performance was impeded by inadequate administrative resources, particularly in the areas of personal contact with recipients and data management.

Physician participation. Many recipients had a regular physician before the PCCM was started. According to data from a monthly survey of a small sample of PPSP enrollees in Michigan, about three-fourths of the enrollees who selected a sponsor chose a physician they were already seeing. If many Medicaid physicians did not join PCCM (and many did not, not only in Michigan but elsewhere), then it is logical that many potential eligibles were left with a dilemma: remain in their established physician-patient relationship or join the PCCM, but not both.

Our six States' experience with enrolling recipients suggests several important points for other states starting a case management program:

1. Phased enrollment is much less taxing on administrative resources and less vulnerable to mix-ups than large-scale, one-time enrollment. Without extraordinary human and data system resources it is almost impossible to establish a large number of satisfactory linkages between enrollees and providers in a short period of time. Another advantage of staged implementation is the luxury of being able, in later stages, to profit from the lessons of earlier stages.

2. Patient assignment to providers is a very sensitive process, best left to personal judgment on a case-by-case basis rather than to a computerized approach. In every PCCM, there were many cases of PCCM enrollees either having no initial preference for a specific case manager or wanting a physician who was not a PCCM member. In some mandatory PCCMs, there were many other cases of enrollees not even responding to Medicaid requests for provider

preference information. In the PCCMs where these patients were assigned through one or another type of mechanical process--computerized or not--serious problems occurred for enrollees, providers and Medicaid administration.

3. PCCM officials should not underestimate the amount of recipient education and information about the program and enrollment procedures (and procedures for 24-hour access, emergency treatment, etc.) needed to avoid implementation problems. Several States learned, to their dismay, that letters and brochures are simply not enough to produce informed consent and compliance with PCCM enrollment. Some States also learned that the amount of time allotted to the explanation of PCCM during AFDC and SSI intake interviews was woefully inadequate.

4. Recipients' dissatisfaction with their assigned primary care physicians typically manifests itself at the time of first medical encounter, not at enrollment. The primary aim in recipient enrollment, then, should be to preserve established pre-PCCM doctor-patient relationships and to maximize the doctor-patient fit for the others through careful assignment.

How Did PCCM Affect Expenditures?

The assessment of expenditure change and other PCCM effects relied almost exclusively on cost and savings data provided by each of the States in our case study sample. Much of the data were produced by the States' own studies and were reported in waiver extension requests submitted to HCFA, typically two and four years after the initial PCCM effective date. In cases where States had more than one analysis available, we relied primarily on the most recent one.

There were important differences in the kinds of comparisons made to assess PCCM savings and calculate PCCM program costs. For example, some States compared PCCM enrollees' expenditures to those of a FFS comparison group during the same time period; some compared pre-PCCM expenditures to post-PCCM expenditures for the same group of recipients; and some used both methods in a "double differences" approach. In addition, some of the applications of these different approaches were simple, while others were very intricate. Even though some are more reliable than others, and they are not strictly comparable across States, Table VI.3 provides a rough picture of reported savings of PCCMs; beginning in the left column with a synopsis of the type of analysis underpinning the findings in the center columns.

All six PCCMs reported savings during the most recent year for which analyses were available. Net savings per enrollee-year ranged from $25.15 in Colorado (1982-83) to $178.32 in Kansas (1984-85). These savings represent from one to 15 percent of what estimated expenditures would have been without PCCM.

In some cases, findings from prior years showed changes far outside this range. These differences may be the result of actual changes in the PCCMs over time, but it is more likely that they reflect differences in the methodology used to assess savings. For example, Kansas initially reported a $21.15 loss from its PCCM but that analysis included only individuals who had been receiving Medicaid continuously during the period under review. When the intermittently eligible were included, savings were identified.

PCCM administrative costs and, in some cases, case management fees or incentive payments, reduced PCCM savings by substantial proportions. The net savings estimates shown are savings in expenditures for services minus the

Table VI.3

PCCM Expenditure Change: A Rough Comparison
(per enrollee year)

PCCM	Type of Analysis	Gross Amount	As Percent of Expenditures Without PCCM	Administrative Cost	Case Management or Incentive Fee	Net Amount	As Percent of Expenditures Without PCCM	Method Limitations
Michigan	Compared paid invoices from the Medicaid billing system for pre and post years for samples of PPSP enrollees and traditional fee for service recipients. Double differences were calculated: controls' pre-post difference minus enrollees' pre-post difference.	$147.25	12.8%	$6.99	$36.00	$104.26	9.1%	The study samples did not include non-continuously eligible recipients, a sizeable portion of the actual PPSP and FFS populations. There was also considerable attrition of the experimental group.
Utah	Compared the total average monthly expenditures for recipients in CHCD, HMO, CHCD case management, and standard FFS for SFY 1985.	(a)	(a)	(a)	$0.00	7.32 for HMO; $39.72 for case mgt; about $33.11 per CHCD enrollee overall	0.7% for HMO; 3.9% for case mgt; 3.2% overall	The analysis lacks adequate controls for factors, such as prior utilization, which could explain observed differences between the groups.
Kansas	Compared average expenditures for 19,616 enrollees in 3 PCN counties with those for 16,414 enrollees in 3 comparable non-PCN counties, 7/84-6/85.	$216.00	18%	$1.68	$36.00	$178.32	15%	The analysis lacks adequate evidence that observed differences are not explained by differences between counties instead of the effects of PCN. GA recipients were also excluded from the analysis.
Colorado	Compared expenditures for approximately 80,000 AFDC adult and children PCPP enrollees to projected expenditures without PCPP (based on a trend line of expenditures for the pre-PCPP period, 7/82-6/83). Estimated savings from non-PCPP initiatives were subtracted from total estimated savings.	$41.31	2%	$4.49	$14.67	$25.15	1%	Projected expenditures without PCPP are based on only four prior quarters, raising questions about their accuracy. SSI noninstitutional aged recipients are excluded from the analysis but they participate in PCPP.

Table VI.3 (continued)

PCCM	Type of Analysis	Gross Amount	As Percent of Expenditures Without PCCM	Administrative Cost	Case Management or Incentive Fee	Net Amount	As Percent of Expenditures Without PCCM	Method Limitations
Nevada	Calculated average monthly costs for each PCCM eligibility group. Results were compared to average monthly costs for like groups under FFS to identify cost differences. Calculations are based on SFY 1985 for 17,211 enrollee months, or about 1400 enrollees.	$121.44	13%	$5.36	$0.00	$116.08	12%	Since PCCM is voluntary, there is maximum opportunity for selection bias. The analysis of comparability was insufficient to establish that inherent differences between FFS and PCCM participants do not explain observed savings.
Wisconsin	Compared capitated rates paid to HMOs to proposed FFS costs which were based on pre-HMO cost per service per eligible month.	$53.49	7-8%	$6.32	$0.00	$47.17	6-7%	Since both the Medicaid population and the provider marketplace change constantly, the largest concern is whether previous year's costs, adjusted for inflation, are an accurate predictor of what FFS would have been without PEI.

SOURCE: State documents. For details see Bell et al., MPE Working Paper 4.5.

a. Computations had administrative costs built in as a percentage of program costs. HMO administrative costs (7.4%) were actually lower than standard program (9.3%). Case management costs were slightly higher (9.5%). Because of the rate method Utah used to calculate its savings, it was impossible to separate out administrative costs in a meaningful way.

additional costs of running PCCM. Some of the figures in the administrative costs column were provided by the States in their cost-effectiveness analysis, others were based on our own calculations from various available data. Total administrative costs, which include case management fees in Michigan and Kansas and incentive payment costs in Colorado, ranged from $5.36 per enrollee year in Nevada to $50.00 in Michigan, and reduced gross savings by a range of 4 percent in Nevada to 46 percent in Colorado.

In Michigan, Kansas and Colorado, payments to case managing physicians (fee or incentive payment) greatly increased PCCM costs. In those States, the payments were considered necessary in order to secure physician participation in PCCM. Perhaps the payments are buying something more, however: two of these three States, Kansas and Michigan, had the first and third ranked highest net savings among the six PCCMs. Perhaps physicians in these States are case managing more rigorously because of the $3.00 monthly fee per enrollee.

In the other three States, it is likely that capitation served to keep PCCM administrative costs relatively low. For example, in Utah, estimated administrative costs for the HMO component--stated in terms of a percentage of program costs--were lower than those for both the case management component and the standard FFS program. In Utah's case, the HMO savings came primarily from eliminating claims processing costs. Similar savings were achieved in Nevada. While Wisconsin's administrative costs were relatively low, savings were not noteworthy. According to Wisconsin officials, the State still had to produce claims-like data for audit purposes. In addition, the State was paying HMOs for detailed utilization data tapes in order to track Medicaid enrollee service usage in the HMOs.

PCCM savings in the six States were a very small share of total Medicaid expenditures for acute care. As shown in column 1 of Table VI.4, one-year savings from the PCCM sample totaled over $19 million. Most of the savings were reported for 1984-85. Since these savings were predominantly in the acute care service area (Nevada and Colorado being the only exceptions with a very few PCCM recipients in long-term care), they were compared to total acute care expenditures in those States for FFY 1984 (Column 3). We found that the total one-year savings from the six PCCMs were equal to a little over one percent of total acute care expenditures (Column 4).

Because of differences in the percent of Medicaid recipients enrolled in PCCM and other variations, the savings to expenditures percentage was considerably higher in several States, as can be seen in the column 4 details. Kansas, with 3.4 percent, appears to have saved the largest amount relative to overall acute care expenditures. Michigan's relatively lower percentage, 0.6, and very high statewide total expenditures greatly influence the 1.1 percent six-state figure. Without Michigan the five-state savings are about 1.8 percent.

The remainder of Table VI.4 shows what the savings-to-expenditure percentage might have been if the States had been able to enroll all the recipients targeted by their PCCMs. Overall the percentage would have been 3.2 percent, almost three times as much as the actual figures States reported. Again, Michigan plays a dramatic role in the potential increase: by increasing its Wayne County PPSP enrollees six-fold, it would increase the total PCCM savings by almost $35 million.

Whatever the savings from PCCM, the six States' Medicaid officials appeared committed to managed health care, via case management or HMO or

Table VI.4

Estimated Maximum Annual PCCM Savings
If All Targeted Eligibles Were Enrolled

PCCM	Recent Savings Through PCCM	Total Medicaid Acute Care Expenditures 1984 (a)	Recent PCCM Savings as a Percentage of Total Acute Care Expenditures	Total Targeted Number of PCCM Enrollees (b)	Hypothetical Savings With Full Enrollment	Savings for All Targeted Enrollees As A Percentage of Total Acute Care Expenditures
Michigan	$6,638,861	$1,033,208,000	0.6%	286,500	$41,258,865	4.0%
Utah	$1,150,341	$60,461,000	1.9%	52,630	$1,742,579	2.9%
Kansas	$3,497,925	$103,237,000	3.4%	20,300	$3,619,896	3.5%
Colorado	$2,012,000	$135,279,000	1.5%	97,400	$2,449,610	1.8%
Nevada	$166,459	$32,794,000(c)	0.5%	5,000	$580,400	1.8%
Wisconsin	$5,614,928	$376,352,000	1.5%	119,036	$5,614,928	1.5%
Total/Average	$19,080,514	$1,741,331,000	1.1%	580,866	$55,266,278	3.2%

SOURCE: State documents. See Bell et al., MPE Working Paper 4.5.

(a) Figures from Holahan and Cohen (April 29, 1986).

(b) Not necessarily all potential enrollees, since some States were not targeting statewide or were not mandating enrollment.

(c) While Nevada included institutionalized aged recipients in its PCCM, few enrolled; among those who were enrolled, savings occurred in the acute care area.

both. In one State, officials reported that they had exhausted all major cost-containment mechanisms short of cutting some services from Medicaid coverage. The PCCM savings were modest, but in the absence of any other more dramatic alternatives, the modest savings were considered well worth the effort. Besides, these officials and others in the six-state sample were so pleased with the perceived effects of their PCCM on access and continuity of care that they would want to continue even if there were no savings.

Using the savings data available from five of six PCCM programs, we compared savings (or increased costs) for enrollees according to categorical eligibility--AFDC, SSI, or General Assistance—and, within AFDC, according to age (see Table VI.5). Three findings stand out:

- Out of four PCCMs for which SSI or over-65 enrollees were compared to AFDC enrollees, three reported greater savings among the SSI/over-65 groups.
- Out of three PCCMs in which age groups were compared, two reported greater savings among adults; the third reported similar savings among both adults and children aged 15-21, but both had greater savings than children aged 0-14.
- In the one PCCM where General Assistance enrollees were compared to other groups, General Assistance group savings were much greater than AFDC group savings, but slightly less than SSI group savings.

Detailed data from Michigan's PPSP and Kansas' PCN provide additional support for the notion that PCCMs are reducing utilization (and expenditures) mostly among those who used services at high rates prior to PCCM. Table VI.6 shows how Michigan PPSP enrollees with high, medium, and no use of services prior to PPSP fared as compared to similar FFS recipients, in terms of pre-PPSP to post-PPSP changes in service utilization and costs. As indicated for every type of service, PPSP had a much more dramatic impact on high service users than on medium or non-users. With respect to overall Medicaid payments,

Table VI.5

Savings Per Enrollee Year By Type of Enrollee

Enrollee Category	Michigan	Utah	Kansas	Colorado	Nevada
AFDC (All)	A 22 percentage point (and $250) difference between PPSP decrease and FFS increase in expenditures.	Case Mgmt: savings of 3.7% ($30) over FFS. HMO: increase of 5.0% ($41) over FFS.	An $11 greater decrease in expenditures	A $15 (2.2%) decrease in expenditures	A $122 (13.5%) savings in expenditures
AFDC (Age 0-14)	A 17 percentage point (and $50) difference between PPSP increase and FFS decrease in expenditures.	No data available.	Age 0-21 A $.58 greater decrease in expenditures(a)	AFDC children: an $11 (2.3%) decrease in expenditures(b)	No data available.
AFDC (Age 15-21)	A 32 percentage point (and $358) difference between PPSP decrease and FFS increase in expenditures.	No data available.			
AFDC (Age 22+)	A 28 percentage point (and $586) difference between PPSP decrease and FFS increase in expenditures.	No data available.	Age 22-40: an $11 greater decrease in expenditures. Age 41-65: A $93 greater decrease in expenditures.	AFDC adults: A $38 (2.9%) decrease in expenditures.	
SSI	A 1 percentage point greater increase in expenditures (but a $14 smaller actual increase).	Case mgmt: Savings of 3.4% ($74) over FFS HMO: savings of 13.4% ($293) over FFS.	Age 66+: A $153 smaller increase in expenditures(a)	No data available	A $144 (18.7%) savings in expenditures(c)
GA Assistance (State Only)	Not applicable	Not applicable	A $139 difference between PCM decrease and non-PCM increase in expenditures.	Not applicable	Not applicable

SOURCE: Data from state documents. For details see Beyna et al., MPE Working Paper 4.5.

Note: No data for Wisconsin. Except for Utah, savings are gross savings, that is, savings before PCCM administrative costs and, in some cases, savings from non-PCCM initiatives are accounted for. Although this changes the dollar figures, the relative differences remain the same.

(a) Analysis of savings by age in Kansas includes all enrollees (AFDC, GA, SSI, MN) in four age groups: 0-21, 22-40, 41-65, over 65. There was no separate analysis for AFDC age groups or for SSI enrollees; presumably many of the over 65 enrollees were SSI recipients.

(b) Analysis of savings by age in Colorado includes two groups: AFDC adults and AFDC children.

(c) Nevada divided analysis into three groups: AFDC, aged institutionalized and aged in the community. We treated the third group as the SSI population for purposes of this analysis.

Table VI.6

Utilization and Cost Outcomes for PCCM Enrollees (vs. FFS Recipients), by Pre-PCCM Non-Use, Medium Use, and High Use of Services (units of use)

Service	Non-Users	Medium Users	High Users
Inpatient Hospital	A 0.15 greater increase in hospital days, a 0.03 greater increase in stays, and a $54 greater decrease in costs.	A 0.12 greater decrease in hospital days and an equal decrease in stays. There was a $53 difference between the PPSP decrease and the FFS increase in costs.	A 1.19 greater decrease in hospital days, a 0.15 greater decrease in stays and a $424 greater decrease in costs.
Emergency Room	A 0.01 smaller increase in units of use.	A 0.13 greater decrease in units of use.	A 0.24 greater decrease in units of use.
Doctor visits	A 0.11 smaller increase in visits and a $2 smaller increase in costs.	There was a 0.71 and $12 difference between the PPSP decrease and the FFS increase in visits and costs, respectively.	A 6.77 greater decrease in units of use.
Lab tests	A 0.02 smaller increase in tests and a $.47 greater increase in costs.	A 2.04 smaller increase in tests and a $17 smaller increase in costs.	A 10.43 greater decrease in tests and a $90 greater decrease in costs.
X-rays	A 0.10 greater increase in x-rays and a $.72 greater increase in costs.	A 0.03 greater decrease in x-rays. There was a $3 difference between the PPSP decrease and the FFS increase in costs.	A 1.27 greater decrease in x-rays and a $24 greater decrease in costs.
Prescriptions	A 0.15 greater increase in prescriptions and a $1 greater increase in costs.	There was a 1.18 difference between the PPSP decrease and th FFS increase in prescriptions. PPSP enrollees had a $9 smaller increase in costs.	There was a 9.61 difference between the PPSP decrease and the FFS increase in prescriptions. PPSP enrollees had a $58 greater decrease in costs.
Total Ambulatory Services	A 0.40 smaller increase in utilization and a $69 greater increase in costs.	There were 3.92 and $96 differences between the PPSP decrease and the FFS increase in utilization and costs, respectively.	A 42.39 greater decrease in utilization and a $333 greater decrease in costs.
Total Medicaid Payments	A 0.30 smaller increase in number of invoice lines and $16 greater increase in costs.	There were 4.10 and $149 differences between the PPSP decrease and the FFS increase in invoice lines and costs, respectively.	A 44.71 greater decrease in invoice lines and a $758 greater decrease in costs.

SOURCE: Data from Michigan's program.

Note: Data represent the differences between PPSP enrollees and FFS recipients, in terms of each group's pre (1984) and post (1985) PPSP change in utilization/cost.

while the program saved $758 per enrollee among prior high users, it saved only $149 per enrollee among medium users and actually cost $16 more per enrollee among prior non-users.

While similar data were not available from any of the other PCCMs, the Kansas PCN may corroborate the Michigan findings in a different way. Using data from the Medicaid Surveillance and Utilization Review System, analysts counted the number of PCN enrollees among the top 500 high expenditure clients for each client category during the quarter just before PCN began and the quarter immediately after. During the pre-PCN quarter, 1,172 recipients from the three PCN counties were listed as high users, but after PCN there were only 1,027. Thus, the number of high users—those using a disproportionate share of Medicaid expenditures declined by 12.4 percent.

As for specific services, the available data from the six PCCMs are fairly consistent with what would be expected. As can be seen in Table VI.7, there were modest to moderate savings attributable to fewer inpatient and outpatient hospital services and physician services. Drug prescriptions or expenditures were lower in four PCCMs and only slightly higher in the other two. In contrast, lab tests and x-rays increased in three of the four PCCMs for which data were available.

Several officials suggested that the increase in lab tests and x-rays might have been due to the fact that many new patient-doctor relationships were established during PCCM implementation. As part of familiarizing themselves with their new patients, it is likely that many physicians ordered more than the usual number of tests and x-rays. In Nevada, where the PCCM was staffed for the most part by medical school residents, the increase in lab and

Table VI.7

PCCM Utilization/Cost Changes for Selected Services

PCCM Service	Michigan (a)	Utah (b)	Kansas (c)	Colorado (d)	Nevada (e)	Wisconsin (f)
Inpatient Hospital	11 percent point greater reduction in hospital days, 6 percentage point greater reduction in stays, and 13 percentage point difference between PPSP decrease and FFS increase in costs.	$70.92 (17%) savings per enrollee year.	3 percentage point greater reductions in expenditures.	6% increase in number of hospitalization episodes.	65% fewer hospital admissions.	29% fewer admissions, 56% fewer patient days and 39% shorter average length of stay under HMO.
ER and Outpatient Hospital	2 percentage point greater reduction in ER visits (no data on ER costs or outpatient services).	$5.40 (7%) savings per enrollee year.	19 percentage point greater reduction in ER and 17 point greater reduction in outpatient expenditures.	46% decrease in ER visits and 23% decrease in outpatient visits; 14%, 23% and 65% decrease in ER, outpatient visit and outpatient service expenditures, respectively.	65% fewer ER visits	49% fewer uses of ambulance and ER services.
Physician Services	19 percentage point greater reduction in doctor visits, and 19 percentage point difference between PPSP decrease and FFS increase in costs.	$5.04 (2%) greater expenditures per enrollee year for these service areas combined.	12 percentage point difference between reduction in PCN counties and increase in non-PCN in expenditures.	19%, 29% and 40% decreases in physician visits, number of physicians seen and physician service expenditures, respectively.	70% fewer physician visits	21% fewer physician visits per enrollee.
Lab Tests and X-ray	24 percentage point greater reduction in lab tests, and 32 percentage point difference between PPSP decrease and FFS increase in costs. 7 percentage point greater reduction in x-rays, and 12 percentage point difference between PPSP decrease and FFS increase in costs.		No data.	No data.	46% more tests and x-rays	3% more lab and x-ray units of service.

Table VI.7 (continued)

PCCM Service	Michigan (a)	Utah (b)	Kansas (c)	Colorado (d)	Nevada (e)	Wisconsin (f)
Prescription Drugs	11 percentage point difference between PPSP decrease and FFS increase in prescriptions, and 13 percentage point smaller increase in costs.	19.80 (18%) savings per enrollee year	4 percentage point greater increase in expenditures.	2% increase in number of prescriptions, 15% decrease in prescription expenditures.	73% fewer prescriptions	4% more prescriptions.
EPSDT	No data.	No data.	20 percentage point greater reduction.	No data.	25% fewer units of service.	No data.

SOURCE: State documents.

Note: Effects are stated in terms of savings/reductions for PCCM enrollees. These data do not take into account the additional costs of administering the PCCM. Therefore, actual savings are not as high as reported here.

(a) Data are based on pre-PPSP and Post-PPSP differences in utilization per enrollee per year for 3,065 enrollees vs. similar differences for 5,200 standard FFS recipients (double difference method).

(b) Data are based on SFY 1985 expenditures for case management enrollees and standard Medicaid recipients. There are no data on HMO enrollees' service by service expenditures.

(c) Data are based on pre-PCN and post-PCN differences in expenditures for PCN enrollees vs. similar differences for recipients in non-PCN counties (double difference method).

(d) Data are based on differences between pre-PCPP and post-PCPP expenditures for 47 enrollees who had been high users prior to PCPP.

(e) Data are based on SFY 1985 utilization rate differences between 2,766 PCCM enrollees and 20,404 recipients in standard fee for service program.

(f) Data compare overall utilization in two HMO counties for periods prior to HMO (1984) and After HMO implementation (1984-85).

x-ray services was further explained by residents' propensity to employ more diagnostic procedures.

Table VI.7 also shows that, in two States where data were available, PCCM enrollees received fewer EPSDT services than their FFS counterparts. Officials in both States explained that, prior to PCCM, EPSDT was a routine service provided by public health and other clinics. Under PCCM, recipients moved to private physicians or, in Nevada's case, medical school family practice residents, many of whom were unaccustomed to EPSDT procedures and schedules. Part of the EPSDT reduction, however, is believed to be an artifact--that is, many EPSDT-like diagnostic procedures were still being done under case management, but were not being reported under the EPSDT service label.

How Was Quality, Access and Enrollee Satisfaction Affected By PCCM?

The States that implemented PCCMs generally did so to reduce costs without reducing the overall quality of medical care. Some States actually saw PCCM as a way of improving access to services and physicians. The States all had Medicaid quality assurance mechanisms that could be expected to maintain quality, and access could be expected to increase through provider assignment, which assures that the enrollee will not be denied care. Furthermore, some States instituted additional quality assurance mechanisms to address specific components of their PCCM designs that could possibly have an adverse effect on access or quality. Michigan Medicaid, for example, contracted with the Michigan League for Human Services, a client advocacy organization, to monitor the PPSP. The League conducted an ongoing survey of PPSP enrollees regarding satisfaction with the service access and quality under PPSP.

Available data on the effects of PCCM on quality and access can only provide suggestive evidence because the States used measures that were not always comparable before and after implementation or across States. They also relied on enrollee satisfaction and provider surveys which varied in quality. Michigan was the only State to conduct a systematic comparison group design survey of enrollee satisfaction. Three of the other States conducted short post-implementation surveys in which enrollees presumably used fee for service (FFS) as their base of comparison to PCCM. Wisconsin conducted a comprehensive survey of satisfaction but did not include a FFS control group or an assessment of current versus pre-PCCM care. There were no survey data available from Utah.

We supplemented these surveys with data collected through telephone and on-site interviews of PCCM providers, officials, and recipient advocacy groups. The findings on enrollee satisfaction are shown in Table VI.8. Survey responses were grouped into three categories: overall satisfaction, satisfaction with access, and satisfaction with quality.

The available evidence from five States indicates that enrollees were generally satisfied. In two of the five there was an indication that recipient satisfaction had improved under PCCM. In Utah, it was the general impression of the local recipient advocacy group that case management worked to enrollees' advantage. In Kansas, the evidence was more concrete. In that State, 46 percent of respondents were more satisfied with medical care under PCN, 12 percent were less satisfied, and 42 percent found care about the same. In three of the five States there was no indication of a change. One of these was Wisconsin, where between 75 and 100 were satisfied with overall care. This and the Kansas result occurred in spite of problems with initial

Table VI.8

Effects on PCCM on Access and Quality: Findings From Surveys on Enrollee Satisfaction

PCCM	Source of Information	Overall Satisfaction	Satisfaction with Access	Satisfaction with Quality
Kansas	Telephone interview, completed in August 1984, of a random sample of 50 PCN clients. This was a post enrollment survey with no baseline or control group.	46% of the respondents were more satisfied with medical care under PCN; 42% found care about the same; and 12% of the respondents were less satisfied with care. Negative comments about PCN focused on the assignment process rather than on any access or quality of care dimension.	Clients cited easier access to medical care as one of the reasons for preferring PCN. 36% of the respondents said it was easier under PCN to reach a physician after regular hours; 60% said it was about the same.	Clients commonly cited better physician-patient relationships as a reason for preferring PCN. Interviewed clients said they were more likely under PCN to seek care when needed. 98% of respondents said their PCN physician was careful and thorough.
Colorado	Post enrollment satisfaction survey sent in December 1984 to a random sample of 600 recipients who had been enrolled in the PCPP for at least six months. 191 responses were received. No baseline survey or control group was used.	Responses were generally positive but there was no indication that satisfaction increased over FFS. 65% of the respondents liked the PPSP concept of having one doctor. 60% of the respondents did not have a clear understanding of the program as explained to them.	Responses were generally positive but there was no indication that satisfaction increased over FFS. - 81% of the respondents were "always" satisfied with the ease of making appointments. - 88% of the respondents have visited their PCP since choosing one. - 21% of the respondents indicated they previously had a problem finding a doctor when they were sick.	
Michigan	Pre- and post-implementation survey of 1,428 PPSP and 1,560 FFS respondents that measured enrollee satisfaction over several dimensions. Monthly recipient surveys carried out under the PPSP monitoring project between January 1983 and April 1986.	52% of PPSP respondents said they would rather get a standard Medicaid card than stay in PPSP. 33% said they preferred PPSP. Those satisfied with PPSP were more likely to have chosen a doctor they were already seeing. The somewhat satisfied groups were less likely to be with sponsor physicians they had seen before.	Access appeared not to have changed for PPSP enrollees. Responses of waiting and travel times, were not significantly different between PPSP and FFS groups and did not significantly change from pre to post periods. 38% of PPSP respondents had travel times < 15 minutes compared to 36% FFS. 63% of PPSP respondents had appointment waits < 2 days compared to 59% FFS. 52% had office waits < 30 minutes compared to 56% FFS.	There is some indication that satisfaction with quality may have declined for PPSP enrollees. Satisfaction with the technical quality of care showed statistically significant declines in both the PPSP and FFS groups from the pre to post periods but the decrease was slightly greater for PPSP respondents. 53% of respondents found care about the same; 28% thought care was better, 15% worse.

Table VI.8 (continued)

POCH	Source of Information	Overall Satisfaction	Satisfaction with Access	Satisfaction with Quality
Utah	Utah Issues publication	Utah Issues, a recipient advocacy group, found that case management worked to the benefit of Medicaid recipients.		
Nevada	Sixty questionnaires are sent out monthly to a random sample of enrollees.	Responses are generally positive but there is no data on whether satisfaction has improved over FFS.		
Wisconsin	A telephone survey of 820 HMO enrollees in late 1985 (about 1-1/4 years after implementation). This was a short, post-HMO enrollment survey. Data were averaged for each HMO and the range between HMOs is presented in the findings. There was no comparison group, and no assessment of perceptions of current vs. pre-HMO care.	In general, there was less satisfaction among enrollees in the Milwaukee HMOs than in Dane County (Madison). This is most likely related to problems with assignment. In Dane County, there was no difference in satisfaction between enrollees who had chosen their HMO and those who had been assigned to one; in Milwaukee, assignees were generally less satisfied than choosers on several items. Overall satisfaction was generally high but there was no indication that it increased over FFS. - The percentage of enrollees satisfied with services received from their doctor/clinic ranged from 75% to 100%. - The percentage of enrollees who would recommend their doctor/clinic to a friend ranged from 76% to 100%.	Satisfaction with access to care was generally high but there was no indication that it increased over FFS. - Satisfaction with the freedom to choose their doctor ranged from 58% to 92%. - Satisfaction with the ability to get an appointment when needed ranged from 76% to 100%. - Satisfaction with the freedom to obtain referrals ranged from 65% to 90%. - Satisfaction with the ability to get care quickly in an emergency ranged from 50% to 100%. - Satisfaction with the availability of care at night and on weekends ranged from 56% to 94%. - Satisfaction with the convenience of the doctor/clinic's location ranged from 67% to 100%.	Satisfaction over several dimensions of quality was generally high but there was no indication that it increased over FFS. Enrollees in every HMO were generally satisfied with the hospital used by their doctor; the opportunity to see the same doctor each visit; the amount of time their doctor spends with them; the willingness of their doctor to listen carefully; the explanations they receive about problems, x-rays, tests; and their doctor's interest in them as a person.

SOURCE: Surveys of Enrollee Satisfaction. For details see Beyna et al., MPE Working Paper 4.5.

enrollee assignment, which led to numerous disruptions in existing physician patient relationships.

In one State (Michigan) there was some indication that overall satisfaction with Medicaid may have declined under PCCM. (It should be remembered that this is both the only State that employed a rigorous comparison group methodology and the State with the greatest degree of recipient resistance to PCCM.) The Michigan survey results showed 52 percent of respondents reporting they would rather have traditional FFS care. Most of this dissatisfaction, however, was concentrated among those who were enrolled with a physician whom they had not used before. Thirty-three percent said they preferred case management.

Enrollee satisfaction with access was high in the four States in which some (though limited) data were available. In Colorado and Wisconsin, satisfaction with access was generally high, although there was no indication that it had improved over FFS. Kansas respondents cited easier access to medical care as one of the reasons for preferring PCCM. Thirty-six percent of the respondents found access to a physician after regular hours had improved. In Michigan, respondents in PCCM had shorter travel times and appointment waits than under FFS but had slightly longer office waits.

In the three States for which data were available, enrollee satisfaction with the quality of care was positive in two of the States and slightly negative in the third. Ninety-eight percent of Kansas respondents found their assigned physician careful and thorough. In Wisconsin respondents were generally satisfied with several aspects of quality, including the hospital used by the HMO, the amount of time their physician spent with them, the explanations they received about problems, and x-rays and tests ordered by

their physician. In Michigan there is some indication that satisfaction was lower among PCCM enrollees. While 53 percent of respondents found care generally about the same and 29 percent thought it was generally better, satisfaction with the technical quality of care (one of several specific categories), which was generally high, showed slightly greater declines under PCCM than in the FFS control group.

Providers and Medicaid administrators perceived PCCM to have had positive effects on access and quality. Table VI.9 shows the findings from provider and administrator surveys and interviews grouped into access and quality of care categories for each of the PCCM States. On balance, physicians were more positive about the effects of PCCM than enrollees, and administrators were more positive than physicians. Administrators and physicians who felt that access had increased generally believed it was due to recipient assignment to a specific physician. Further, they felt that the enrollees who previously had not had a regular physician benefited the most. Those who felt quality of care had increased generally felt it was due to increased continuity of care and the establishment of a medical home.

In general, Medicaid administrators believed that access had increased. In Kansas, Nevada, and Wisconsin, this increase was attributed to physician assignment of adults who previously did not have a regular physician. In these three States, administrators also felt that the quality of care had improved under PCCM. In Kansas and Nevada this was attributed to better continuity of care and in Wisconsin to the HMOs' self interest in providing preventive care to avoid costly illness in the future. In Utah and Colorado access was believed to have improved due to an increase in the number of physicians participating in Medicaid.

Table VI.9

Effects of PCCM on Access and Quality: Findings from Provider and Administrator Surveys and Interviews

PCCM	Source of Information	Access to Services	Quality of Care
Kansas	Survey of 50 PCN physicians conducted in August 1984, 6 months after implementation.	The majority of respondents did not feel that access had increased substantially for enrollees.	The majority of respondents felt that the quality of medical care had not changed much under PCN.
	On-site interviews with physicians and Medicaid administrators conducted in March 1986, 2 years after implementation.	Medicaid administrators believed that access had increased particularly for adults who previously did not have a regular physician.	Interviewed physicians all felt that PCN improved continuity of care, thereby improving the overall quality of care.
		Medicaid administrators also felt that access had not changed much for children who historically had regular physicians.	Medicaid administrators also believed that continuity of care had increased.
Colorado	Survey of 614 PCPP physicians		The majority of respondents felt that PCPP encouraged the coordination of services.
	Survey of 315 specialist physicians	The majority of respondents felt that PCPP had not hindered recipient access.	
	Survey of 51 (out of 61) county PCPP liaisons	The majority of respondents agreed that there were enough PCPP physicians to allow recipients to choose a suitable doctor.	
	On-site interviews of physicians	Interviewed physicians agreed that the PCPP hotline increased access by enabling recipients to call this toll-free number for information on physicians that were accepting new patients.	Interviewed physicians believed that the program has a positive effect on quality of care if for no other reason than recipients having a medical home with their medical files in one place.

Table VI.9 (continued)

PCCM	Source of Information	Access to Services	Quality of Care
Colorado (cont.)	On-site interviews of administrators	Interviewed administrators believed PCPP had increased access by the addition of the hotline and by attracting additional Medicaid providers.	
Michigan	1984 Survey of physicians in Wayne County, that assessed attitudes regarding the likely effects of PPSP.		The majority of physicians predicted that there would be no effect of PPSP on the physician-patient relationship.
Utah	Telephone interviews of Medicaid administrators conducted August 1986.	Utah officials believed that CHCD had increased the number of providers serving Medicaid recipients (thus increasing access), but no hard data were available to substantiate the claim.	
Nevada	On-site interviewing of administrators and physicians conducted in April, 1986, 2 years after implementation.	Interviewed physicians and administrators believed that access had increased for those enrollees who previously did not have a regular physician.	Interviewed physicians and administrators felt that quality of care for Medicaid recipients had greatly improved due to increased continuity of care.
Wisconsin	On-site interviews with Medicaid and HMO administrators conducted in May, 1986, 22 months after implementation	Interviewed Medicaid and HMO administrators believed that access may have improved for enrollees that previously did not have a regular physician. However, the assignment process created a substantial problem with access for those enrollees who wre not assigned to their regular physician.	Interviewed HMO administrators believed that quality of care had improved from a continuity of care perspective. Medicaid administrators articulated the belief that quality of care was resulting from the HMOs' self interest in taking care of problems before they become costly.

SOURCE: Provider and Administrator Surveys and Interviews. For details see Beyna et al., MPE Working Paper 4.5.

Physicians in four of the five States for which data were available believed PCCM had had a positive effect on quality. Three of these States' providers felt that PCCM had also increased access. In Colorado, physicians believed that access had increased through the PCPP hotline, which enabled recipients to call a toll-free number for information on physicians who were accepting new patients. Wisconsin HMO administrators and Nevada physicians felt that access increased for those who previously did not have a regular physician.

This evidence runs contrary to fears that quality and access would suffer, especially under mandatory enrollment and capitated reimbursement. Mandatory enrollment, it is argued, prevents Medicaid recipients from "voting with their feet." Capitated systems are particularly criticized in this regard because of the limited choices offered among HMOs. However, capitated plans are also a concern because they may provide financial incentives to under-serve. This is a concern of HMOs in general and is not a problem peculiar to those that serve Medicaid. This general problem has been addressed by State and Federal regulations and monitoring.

In the FFS PCCM models, mandatory enrollment does not substantially restrict enrollees as long as they retain the right to change physicians. There is a potential problem in mandatory capitated plans (e.g., Wisconsin's PEI), however, in that Medicaid enrollees do not have the option of returning to FFS, but physician choice is probably as wide as before in most cases.

Despite potential problems, the available evidence generally suggests that quality, access, and enrollee satisfaction have not declined under PCCM. There are, however, methodological limitations in the analyses underpinning this conclusion. We recommend more use in the future of pre-post

comparison and control group survey designs, which provide better means of assessing change attributable specifically to PCCM.

Summary

Many States, including several of the largest, have responded to the new flexibility in restricting Medicaid enrollees' free choice of providers. The many who chose primary care case management (PCCM) as the way to structure their response expected to reap savings and improve service access and quality.

Savings. All six case-study PCCMs reported net savings per enrollee-year compared with fee-for-service (FFS), ranging from less than 1 percent for Utah's prepaid HMO enrollees to 15 percent for Kansas's non-capitated program. PCCMs generally do not yet include all of the originally targeted recipients, so reported savings are a very small percentage of total acute care costs, ranging from 0.6 percent for Michigan to 3.4 percent for Kansas. If PCCMs were expanded to include their full target populations, the available findings suggest that savings as a percentage of total acute care expenditures would rise to 1.5-4.0 percent, with the Wisconsin HMO program the lowest and the Michigan non-capitated program the highest.

Available utilization analyses provide indications of the redistributive effects of PCCM:

- Prior non-users--those without a medical home--use more services.
- Services to children do not decrease and the best evidence suggests a possible increase in utilization for this vital population.
- Adult enrollees, the most likely to overuse services if not managed by a single physician, evidence the greatest declines in utilization.

Use of services decreased as expected according to the limited available data: inpatient and outpatient hospital (including emergency room), physician office visits, and prescription drugs decreased; laboratory and x-ray decreased in one State, but rose in the other three States where data were available.

Improved Service Access and Quality. In some PCCMs, the unexpectedly complicated enrollment process caused numerous disruptions in recipients' existing physician-patient relationships or assignment to an inappropriate physician. But the fallout in terms of recipient dissatisfaction with access and quality of care seems to have been negligible. Satisfaction with PCCM seems plausible, especially for recipients who were able to retain their pre-PCCM physicians or who had difficulty accessing care before PCCM because they lacked an established or appropriate medical home.

For those interested in PCCM, the message to date from the case study States is fairly clear: PCCM appears to yield positive access, quality, and savings benefits, but designing and implementing a Medicaid case management program can be difficult. When designing a PCCM program, crucial decisions must be made about the types of recipients to include, whether to make participation mandatory or voluntary, how to reimburse case manager providers, which services to place under case manager authority, and whether and how to phase in implementation. During implementation, extreme care and substantial resources must be devoted to securing sufficient provider participation, matching enrollees with appropriate case managers, educating providers and enrollees in proper procedures, producing timely and useful data on enrollment and utilization, and assessing program effectiveness. These are the most critical design and implementation concerns, but not the only ones. States

considering PCCM would be well advised to prepare to invest substantial administrative resources into planning, starting and monitoring a new case management program, whatever its basic structure and provisions. They would also be wise to set modest expectations regarding savings and other program benefits until more careful studies are conducted to validate the current findings.

Despite the challenge of starting such a program, the weight of the available information from the case study PCCMs suggests that savings and other benefits should be expected. Yet because of methodological limitations in the available analyses of effects, States starting a PCCM should also be cautious when defining potential effects. As would be expected for any complex service delivery/reimbursement initiative that varies in operational form across States, continuing and progressively more discriminating analysis will be needed before a valid determination of PCCM efficacy is achieved. The available information indicates that future study is warranted because the PCCM concept looks like it works and is therefore likely to continue to play a prominent part in many States' plans for Medicaid reform. Particularly intriguing is the question of whether non-capitated models of PCCM are as effective as indicated by State analyses. If so, this model offers many States a more politically feasible avenue to changing the way physicians participate in Medicaid.

VII. COST SHARING

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 significantly altered the longstanding Medicaid provision allowing States to require recipient cost sharing for services. In a major shift in emphasis, TEFRA permitted States to target specific groups of categorically needy and medically needy recipients and specific mandatory and optional services. As a result of allowing cost sharing on mandatory services for categorically eligible enrollees, it also increased the share of Medicaid acute care expenditures that can be subject to cost sharing from an estimated 38 to 56 percent. This chapter summarizes our findings about the evolution and effects of cost sharing in Medicaid, including the influence of TEFRA provisions, and discusses what may be implied for States that have adopted or are considering Medicaid cost sharing.

Data Sources and Methodology

This study of cost sharing is essentially qualitative. The first step was to gather information on cost sharing by compiling a history of Federal legislation and an inventory of States' Medicaid cost-sharing initiatives and pertinent literature. This early phase of the study also examined other materials provided by HCFA and the States and included interviews with

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This chapter summarizes findings presented in S. K. Beck et al., "A Review of Cost-Sharing in Medicaid" MPE Working Paper 6.1. Two interim papers completed for the Medicaid Program Evaluation by Syracuse University and the National Governor's Association provided important material for Working Paper 6.1: Steve Long et al., Background on Cost Sharing and Its Use in Medicaid, Syracuse, New York: Syracuse University, 1986, and Ian Hill, "Recipient Cost Sharing Under Medicaid," in Richard Curtis and Ian Hill (Eds.), Affording Access to Quality Care, Washington, D.C.: National Governor's Association, July 1986. The detailed research for both of those documents was carried out by Claudia Hanson of the National Governors' Association.

knowledgeable people, including personnel in the HCFA central office, staff of the Health Insurance Association of America, and research groups involved in cost-sharing analyses. The focus at this stage was on the number and characteristics of current or past cost-sharing programs in Medicaid and on the use and effects of cost sharing in the private sector.

Next, case studies of cost-sharing programs were conducted in nine States that have been heavily involved in cost sharing. The nine states are: Iowa, Kansas, Mississippi, Missouri, Montana, Nevada, North Carolina, South Dakota, and Wisconsin. Three factors were used to determine which State cost-sharing programs to include as candidates for case study: duration, breadth of service inclusion, and the extent to which they included selected services that are typically included in cost-sharing programs (prescribed drugs, outpatient hospital, optometric, and dental services). States were rated on each of these factors, and those States with the highest composite ratings were selected. The nine-State review included telephone discussions with Medicaid State and regional cost-sharing program personnel; local welfare eligibility workers, providers, recipients and/or their advocates; State fiscal intermediaries; and State medical societies.

Finally, field visits were conducted in three States: Nevada, North Carolina and Wisconsin. These States were chosen, not only because they were willing to cooperate, but also because of their longstanding and in-depth involvement in Medicaid cost sharing and/or the availability of relatively careful data collection and analyses regarding cost-sharing experience in their States.

Needless to say, the discussion in this chapter provides suggestive rather than definitive evidence, particularly in the area of cost-sharing effects, because it is based solely on existing studies by selected States and the qualitative information collected in interviews with knowledgeable people.

What is Cost Sharing?

Cost sharing is a generic term which typically includes one or more of three methods insurers use to share their financial risk with those they insure--deductibles, coinsurance, and copayments.[1] Deductibles require the insured person to be responsible for a specific amount of incurred medical expenses during a set period of time before the insurer assumes financial risk. For example, an insured person may be financially responsible for the first $100 of health care expenses during a calendar year before insurance benefits commence. Coinsurance is a fixed percentage of health care costs for which an insured person is financially responsible. It becomes effective after the beneficiary has "met" the calendar year deductible, if there is one. The most commonly used coinsurance rate is 80/20: the insurer pays 80 percent of the submitted claims and the insured is responsible for the remainder. Copayments, the most popular form of cost sharing under Medicaid, are fixed dollar amounts that the recipient must pay for a specific unit of

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1. In a sense, insurance premiums and enrollment charges are also cost-sharing methods, but they are paid up front and are independent of individual utilization of services. They represent the amount the insurer must charge at least to break even, based on assumptions about the future price of services and utilization among the entire insured population. In Medicaid, premiums and enrollment fees (which States can charge their medically needy recipients) do indeed reduce the States' and Federal government's expenditures, but they remain unrelated to individual utilization and services costs. As such, premiums and enrollment fees are excluded under the generic term "cost sharing" in the remainder of this report.

service at the time of service delivery. Copayments in the private sector typically range from $.50 to $25.00, depending on the service. They are charged on each unit of service, and do not count toward reaching deductible limits or coinsurance percentages.

In addition to reducing the insurer's cost through out-of-pocket payments by the insured, these three forms of cost sharing are believed to save money by lowering utilization of services. If a beneficiary knows that he/she will have to pay part of the bill for a specific medical service, he/she may opt to delay the service or forego it entirely. As one observer has put it, cost sharing serves, then, two important purposes:

> As a utilization control device, cost sharing helps induce patients to be economically prudent when deciding to purchase health care services. As an expenditure control device, cost sharing allows third party payers to shift a portion of the cost of care to consumers of health services.[1]

The logic of cost sharing, thus, is straightforward, but its actual implementation and effects are considerably more complex, especially in Medicaid. Cost sharing in Medicaid is governed by specific laws and regulations which have periodically changed the basic rules about who can be required to share costs, which services can be affected, and how much can be charged. Further, the relationships between cost sharing and service utilization, on the one hand, and between utilization and actual savings, on the other, are not as simple as they appear. For example, some research

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1. Ian Hill, "Recipient Cost Sharing Under Medicaid," in Richard Curtis and Ian Hill (Eds.), Affording Access to Quality Care, National Governor's Association, July 1986, p. 151.

suggests that cost sharing can produce utilization patterns that cost more in the long term.[1,2]

The use of cost sharing has been a State option since Medicaid began in 1965. The original Social Security Act [Title XIX, Section 1902(a)(14)] allowed States to adopt cost sharing with certain limitations. Cost sharing could be imposed on the categorically and medically needy for all services except inpatient hospital services, and charges had to be income-related. In 1967, Congress altered its position to permit cost sharing on inpatient hospital services for the medically needy. When the first cost-sharing regulations were promulgated in 1969, the categorically needy were exempted from cost sharing on any service, leaving only the medically needy subject to cost sharing. However, the requirement that cost sharing be income-related was considered by the States to be so administratively burdensome (since charges would have to vary depending on an individual's income) that none of the States implemented cost sharing programs under this rule.

In 1972, the categorically needy became subject to cost sharing on optional services. In addition, the requirement that the costs be income-related was replaced by a rule that required that they be "nominal" (for noninstitutional services, using a scale tying the copayment amount to the provider's charges or assigning a standard copayment based on average or typical State payments for a specific service; for institutional services, a

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1. R.H. Brook, et al., The Effect of Coinsurance on the Health of Adults," Rand Report No. R-3055-HHS, December, 1984, and Martin F. Shapiro, et al., "The Effects of Cost Sharing on Seeking Care for Serious and Minor Symptoms," Annals of Internal Medicine, February, 1986.

2. L. Jay Helms, et al., "Copayments and Demand for Medical Care: The California Medicaid Experience," Rand Report No. R-2167-HEW, February, 1978.

ceiling of 50 percent of the agency's payment for the first day of care). In addition, if States chose to impose deductible or coinsurance charges, rather than copayments, the charges were limited to a $2 per family per month deductible and a 5 percent coinsurance charge.

With the switch to nominal payments, cost sharing finally became a reality in Medicaid. The change from income-related to nominal cost sharing in 1972 was critical, but it is also likely that States were becoming increasingly willing to make such a change because of both the growing need to contain costs and the example of the private sector. Private insurers were, by number and degree, increasing their reliance on cost sharing to contain costs, and there was a growing perception that cost sharing saved money.

TEFRA (1982) vastly complicated cost sharing under Medicaid by introducing a whole set of finer distinctions defining the specific services that were subject to cost sharing, either at a defined nominal rate or at a higher penalty rate (i.e., through a waiver for nonemergency use of emergency room services). The gross distinctions of categorically and medically needy, and of mandatory and optional services, were set aside. Specific recipient groups and services became exempt:

- Services provided to persons under age 18, or at State option, persons under 21, 20, or 19, or "reasonable" categories of persons older than 18;
- Pregnancy-related services or, at State option, any services provided to a pregnant woman;
- Any patient in a medical institution who is required as a condition of receiving services in the institution to spend all but a minimal amount of income for medical services;
- Emergency services;
- Family planning services; and

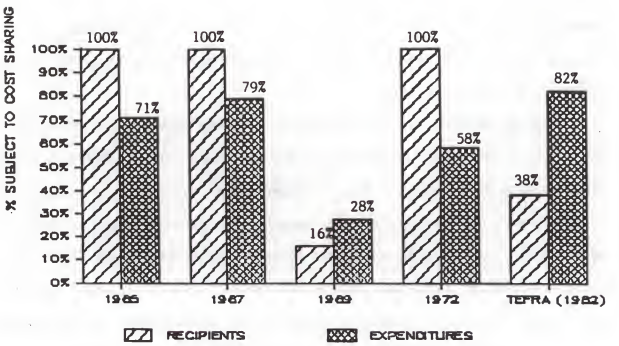
- Services provided by a health maintenance organization to enrolled categorically needy, or at State option, all covered persons.

The motivation for the TEFRA changes was concern with rising expenditures and specific ideas on which service use should or should not be discouraged. For example, on the one hand, recipients judged to be making unnecessary use of costly hospital emergency room services can now be required to pay double the nominal copayment (waiver required); on the other hand, services like maternal care are exempt from cost sharing. As shown in Figure VII.1, the percentage of total Medicaid recipients TEFRA targeted for inclusion in cost sharing was relatively low compared to those covered under previous legislation, but the percentage of Medicaid expenditures subject to cost sharing was relatively high.

Although deductibles and coinsurance are more prevalent in the private sector, copayments are the most used form of cost sharing in Medicaid. The prominence of copayments can be attributed to several factors. Unlike coinsurance, copayments are a fixed amount, thus assuring that recipients will not be vulnerable to major increases in cost-sharing responsibilities through increased need for services. Unlike the typical deductible, which is often applied across the board, they are based on use of selected services, thus enabling Medicaid to target specific highly or inappropriately used services. Monitoring deductible payment levels is also administratively burdensome. Furthermore, copayments, in most cases, can be required up-front at the time of service delivery, and impose a minimal administrative burden to the Medicaid program after initial implementation. Twenty-five of the 26 Medicaid cost-sharing programs currently operating use copayments; only three programs

FIGURE VII .1

IMPACT OF LEGISLATIVE CHANGES ON PERCENTAGE OF RECIPIENTS AND EXPENDITURES POTENTIALLY SUBJECT TO COST SHARING



Source: Medicaid State Tables for FY 84, Office of the Actuary, Health Care Financing Administration. See Beck et al., MPE Working Paper 6.1.

use coinsurance and none use deductibles. As a result, our study focused on States' experience with Medicaid copayments.

What Is Known from Cost Sharing Research?

The most thorough and widely cited study of cost sharing in the private sector is the Rand Health Insurance Study, a large-scale controlled experiment.[1] For a period of five years between 1975 and 1980, different randomly assigned participant groups received medical care that was subject to different percentages of cost sharing--0, 25, 50, and 95 percent respectively. Different levels of cost sharing were applied so as to measure their varying effect on utilization and expenditures. The Rand study yielded a wealth of findings, all of which support the conclusion that cost sharing generally reduces service utilization and expenditures for health care, at least over the period covered by the experiment. But this is not the whole cost-sharing story. There remain several important questions about the implementation and effects of cost sharing that warrant continuing attention:

- Is the reduction in utilization a permanent reduction, or does it gradually disappear as individuals become accustomed to their cost-sharing responsibilities?
- Will some individuals deny themselves needed care because of the cost-sharing burden, experience deteriorating health as a consequence, and require more expensive care in the long run?
- Do the very poor (e.g., Medicaid recipients) differ from the general population in terms of cost sharing's effects on service utilization, health outcomes, and expenditures?

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1. Joseph P. Newhouse, et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," Rand Health Insurance Experience Series, Rand Corporation, January, 1982.

- How does cost sharing affect providers, especially those in Medicaid?

There has been very little research on these questions. In one Canadian study, it was found that copayments reduced total utilization of physicians' services (more so among the poor than others), but the reduction subsided within two years.[1] As for the long-term effects of cost sharing on health status and health care expenditures, the little research that has been done suggests that cost sharing may have a negative effect on health status, and that the very poor may be more negatively affected than the general population.[2]

Finally, another Rand study compared Medicaid recipients' use of cost-shared versus non-cost-shared services. The findings suggest that Medicaid recipients may be restricting their use of ambulatory services (cost-shared) to such an extent that their health status deteriorates, leading to eventual increased use of other, more costly services.[3]

The research to date suggests, then, that cost sharing on ambulatory care services does reduce utilization, and that the effect varies with the percentage of costs shared and the financial status of those on whom the cost sharing was imposed. It is not clear, however, that cost sharing necessarily saves money for the insurer in the long run and it may lead to other

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1. R. G. Beck, "The Effects of Copayment on the Poor," Journal of Human Resources, Vol. 9, No. 1, Winter, 1974, pp. 129-142.

2. R.H. Brook, et al., The Effect of Coinsurance on the Health of Adults," Rand Report No. R-3055-HHS, December, 1984, and Martin F. Shapiro, et al., "The Effects of Cost Sharing on Seeking Care for Serious and Minor Symptoms," Annals of Internal Medicine, February, 1986.

3. L. Jay Helms, et al., "Copayments and Demand for Medical Care: The California Medicaid Experience," Rand Report No. R-2167-HEW, February, 1978.

undesirable outcomes, namely reduced access to Medicaid providers and less effective overall health care.

How Have States Responded to the Cost-Sharing Option?

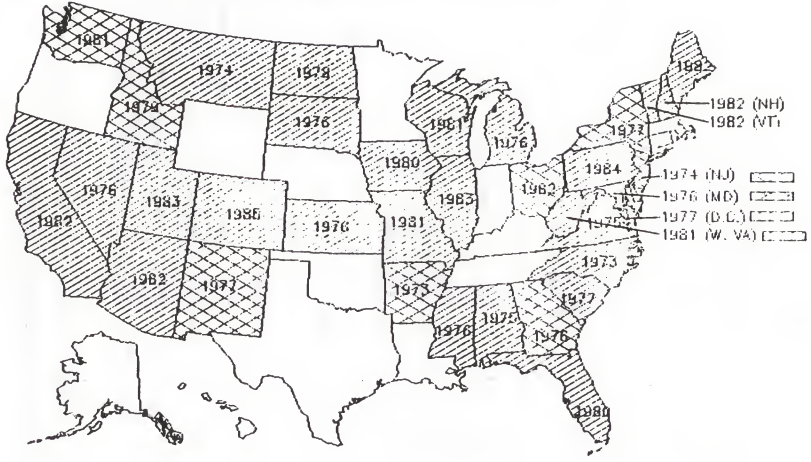
Two-thirds of the States have experience with cost sharing under Medicaid. As shown on the map in Figure VII.2, since 1973 at least one State Medicaid program each year has adopted cost sharing up to 1985. The rate of adoption was particularly high in 1976-77 and 1981-82 because health care costs were rising especially rapidly, and cost sharing was seen as one method to contain costs. Although not as compelling, States in our review cited a desire to promote recipient self sufficiency and favorable changes in Medicaid legislation among additional reasons for implementing cost sharing in their Medicaid programs.

While most States' decisions to adopt cost sharing have been driven by economic considerations, several decided eventually to drop cost sharing for administrative reasons. Six of the nine States to drop cost sharing did so in response to TEFRA in 1982; most cited increased administrative complexity (e.g., TEFRA's exclusion of specific subgroups of recipients and services) as the major reason. No States have decided to drop cost sharing since 1983.

States' responses to cost sharing do not seem related to geographic location, size of State Medicaid expenditures or relative generosity as indicated by the State's AFDC payment standard. Rather, States that have been involved in cost sharing appear to be generally representative of all States as a whole.

State programs vary in terms of services covered, enrollees included, amount of copayment(s) and program administration.

FIGURE VII.2
A NATIONAL LOOK AT MEDICAID
COST SHARING, WITH YEAR OF ADOPTION



Services. Federal regulations define the services subject to cost sharing. As would be expected from the legislative history, optional services are more likely to be part of a State's copayment program than mandatory services, although there is an increasing emphasis on mandatory services now that copayments can be imposed on the categorically needy for these services. All of the States to adopt cost sharing since the passage of TEFRA have included mandatory services. The three States that most recently adopted cost sharing implemented comprehensive programs, including a range of nine to 23 services covered by their Medicaid programs.

The most common cost-shared service is prescription drugs. It was the sole cost-shared service in 54 percent of the programs among the 35 States with cost-sharing experience, and was included in 80 percent of the programs. The reasons given by the nine case-study States are several. Unlike most services, payment for prescription drugs occurs prior to service delivery, making collection extremely straightforward. In addition, it is the most used (1.23 prescriptions per recipient in 1980), compared to .11 inpatient discharges and .59 physician visits, and the fifth most expensive service (6 percent of total Medicaid expenditures nationally).[1] Dental care (included in 49 percent of the programs) and optometrist services (included in 40 percent) follow.

Table VII.1 shows the mandatory and optional services included by the 26 State cost-sharing programs in operation in late 1984. Eight States included only one service but the number of services ranged to a high of 21 (Wisconsin). Ten of the 26 States included 10 or more services.

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1. Health Care Financing Program Statistics, The Medicaid and Medicare Data Book, 1983, HCFA, April, 1984.

Table VII.1

Frequency of Cost Sharing, by Service
(26 cost-sharing programs)

Service	Number of States
Mandatory	
Inpatient	11
Outpatient	11
Physician	11
Rural Health Clinics	5
EPSDT (18-20 year olds)	2
Non-Emergency Services in Emergency Room	4
Outpatient X-Ray	1
Home Health	2
Optional	
Prescribed Drugs	22
Dental	12
Prosthetics (including Dentures)	8
Optometrists	13
Eyeglasses	10
Audiological	5
Hearing Aids	7
Chiropractors	9
Medical Supplies	5
Durable Medical Equipment	5
Private Duty Nursing	1
Outpatient Psychotherapy	9
Medical Day Treatment	1
IMD	2
Physical and Occupational Therapy	5
Speech, Hearing Language Therapy	5
Transportation	6
Clinics	6
Podiatrists	10
Home Dialysis	1
Surgical Centers	2
Acupuncture	1
Orthopedic Shoes	1
Mental Health Clinics	1

SOURCE: Figures based on Medicaid State tables for Fiscal Year 1984, Office of the Actuary, Health Care Financing Administration. Long-term care and family planning expenditures not included.

Although recent research has demonstrated that cost sharing on emergency room use reduces utilization, especially inappropriate utilization, among the poor,[2] and although States are permitted, with a waiver, to charge twice the maximum copayment amount for nonemergency ER visits, they do not usually impose cost sharing on such use. Only six States have imposed copayments on nonemergency use of ER and none charge double the maximum nominal amount.

Several of the 26 States with cost-sharing programs cited reluctance to initiate the waiver request as one reason for their decision against imposing non-nominal cost sharing on non-emergency use of the emergency room. They also cited administrative difficulty. Unlike most cost sharing, inappropriate use of an emergency room is difficult to accommodate in the claims processing system and, in some instances, difficult for emergency room attendants to assess. In addition, many States report that they have other policies in effect for controlling emergency room utilization.

Eleven States increased the number of services subject to cost sharing after starting their programs. Among States not increasing the number of services, the most frequently cited reason was administrative costs--computer system changes, provider and recipient notices, etc. Generally, the reasons given for State decisions on which services to include in tighter cost-sharing programs varied from State to State, and none had any data to support why particular services were included in their cost-sharing programs.

Copayment Amounts. There have been legislative limitations on copayment charges since the inception of cost sharing in Medicaid. However, it was not until February 1974, in regulations implementing the 1972 amendments, that

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2. O. Grady, K.F., et al., "The Impact of Cost Sharing on Emergency Department Use," Rand Corporation, October 1985.

dollar amount maximums were specified. In February 1983, HCFA revised the maximums as follows:

States' Payment for the Service	Maximum Copayment
Noninstitutional Care:	
$10 or less	$.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00
or a standard copayment based on the average or typical charge.	
Institutional Care:	
50 percent of the State payment for the first day of care per admission	

Copayment charges among the 25 copayment programs do not exceed the $3.00 maximum on noninstitutional care. Institutional care copayment charges are as high as $75 per stay. Although the per service unit charge may not exceed $3.00, a recipient may have many unit charges under one service category. For example, a $3.00 copayment on inpatient hospital services may represent a $3.00 charge for each inpatient day, resulting in a much higher total copayment charge for the hospital stay.

Only five States have chosen to put a limit or cap on recipient financial liability, and these vary greatly in the form of the limit (Table VII.2). While Colorado, Montana, and Pennsylvania set limits on total individual liability for all services, North Carolina and Wisconsin favor limits on total liability on a service-by-service basis. Administrative complexity is the most commonly cited reason that more States do not implement this recipient safeguard.

Program Administration. Administrative difficulty and costs are the most commonly cited barrier to States' adoption of cost sharing. Some States have

Table VII.2

Ceilings on Recipient Liability

State	Date	Ceiling on Recipient Liability
Colorado	1985	Ceiling of $60 per individual per calendar year.
Montana	1983	Cost-sharing cap per family (regardless of family size) of 5 percent of the maximum yearly AFDC grant for one adult in effect at the end of the State fiscal year.
	1983	Inpatient hospital services: $3.00/day, not to exceed $66.00/admission.
North Carolina	1979	Inpatient hospital services: No copayment after 30 days or copayment not to exceed 50 percent of first day's cost (no longer in effect; copayment on hospital services was dropped in 1984).
Pennsylvania	1984	Ceiling of $90 per recipient in a six-month period.
	1984	Limit on copayments of $21 per hospital admission.
Wisconsin	1983	Inpatient hospital and IMDs: $3.00 per day, up to $75.00 copayment limit per stay.
	1983	Prescribed drugs: $5.00 per calendar month for prescriptions filled at a single pharmacy.
	1984	Physician visits: No copayment after first six visits to a single physician in a calendar year.
	1984	Outpatient psychotherapy: No copayment for services above 15 hours or $500.00 of equivalent care per calendar year. (Services over these limits are pre-authorized.)
	1984	Physical therapy, occupational therapy, speech and hearing therapy: No copayment after 30 hours or $1,500 of equivalent care per calendar year.

SOURCE: National Governors' Association, "Medicaid Cost Sharing by State," September 1985.

estimated that administrative costs would exceed the savings from decreased Medicaid expenditures, but few States have actually assessed the costs. In Wisconsin, for example, cost sharing was initially rejected twice because the State assumed that administrative costs would cancel out program savings. No formal assessment of likely start-up and on-going costs was completed.

The nine case-study States report that the most difficult problem is claims processing changes. States must define the services and recipients subject to cost sharing and reprogram the claims processing and recipient identification (medical assistance card) systems. The States with caps on recipient liability, such as Wisconsin and Colorado, had even more difficulty adapting their claims processing system. Wisconsin's fiscal intermediary reported that, although they do not have records of the cost of developing and implementing the cost-sharing change in the computer system (since many other system changes occurred at the same time), the cost-sharing changes were very difficult when compared to other system changes requested by Medicaid.

The most difficult claims processing changes were those required by TEFRA. The pre-TEFRA exemptions, although cumbersome, were more straightforward in terms of edits in the claims processing system--identifying only categorically versus medically needy eligibles and mandatory versus optional services. With TEFRA, however, States first had to develop definitions for the exemptions and then program them into computer systems. The exemption of pregnant women or pregnancy-related services was reportedly the most difficult to administer, followed by emergency services and family planning services.

The second most difficult administrative problem concerned provider participation in cost sharing--their understanding of the program and willingness to adhere to program guidelines. Four of the nine States in the

case-study sample sought cooperation from Medicaid providers prior to the implementation of cost sharing, with beneficial results. For example, in Wisconsin, the Medical Society was able to avert some potential problems by encouraging Medicaid to soften its stance on providers being required to collect the copayments. Although the level of initial involvement varied by State, providers in all States were sent bulletins explaining the cost-sharing program, particularly provider responsibilities.

Prior to TEFRA, it was much easier to tell providers which recipients and services were subject to cost-sharing and how much to collect. In States with medically needy programs, cards for medically needy and categorically needy differed. Providers of services on which copayments were charged were sent provider bulletins noting the cost-sharing charges. Providers of mandatory services then could identify medically needy recipients by their medical assistance card and charge them the copayment; providers of optional services simply charged all Medicaid recipients the copayment.

After the passage of TEFRA, however, identification of exempted recipients and services became much more difficult. Of the nine programs in the case study, only three, Kansas, Nevada and Wisconsin, clearly identified exempt recipients (children and institutionalized individuals) on their medical assistance cards. The remaining six States relied on the provider to identify the exempt recipients.

None of the nine States monitor providers to determine whether copayments are actually collected and collected from the appropriate recipient groups. In the three States we visited, sanctions against providers who do not collect copayments were nonexistent. Only two of the nine States had considered provider sanctions and none had actually implemented such sanctions. Those

States raised the possibility of terminating non-compliant providers from the program (one of these States has since dropped copayments). Since sanctions were not actually invoked, most States reported that "having a talk" with non-compliant providers had been tried and found effective.

According to anecdotal evidence most providers in Nevada and North Carolina collect copayments, partly because of their strong belief in the concept. In contrast, providers in Wisconsin "attempt" but do not necessarily collect copayments—in part, because providers do not feel Medicaid recipients should be subject to additional financial responsibility. Some providers neglect to collect copayments because the expense of pursuing negligent recipients exceeds the cost of the nominal copayments. Further, in some instances, providers waive copayments in an attempt to solicit business. Retail pharmacies in Nevada and other States complained that competitors, particularly large chains, were not charging copayments in full in order to attract Medicaid customers. (In some States, this practice has been forbidden.)

With the exception of Arizona, which is under a waiver, all 26 cost-sharing States remit the reimbursement payment minus the expected copayments amount regardless of whether or not the provider collects the copayments. Providers who do not wish to absorb the cost of uncollected copayments, either for philosophical and/or financial reasons, generally find the enactment of TEFRA Section 1916(c) controversial:

> (c) The State plan shall require that no provider participating under the State plan may deny care or services under the plan on account of such individual's inability to pay a deduction, cost-sharing, or similar charge. The requirements of this subparagraph shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost-sharing or similar charge.

Some providers believe that the enactment of this provision will result in a greater financial burden. Pharmacists in several of the nine case-study States complained about recipients who declined to pay copayments and then purchased other items. Some pharmacists believe that it would be more prudent to terminate their association with the Medicaid program should their State aggressively enforce this TEFRA provision. The provision has, in effect, created a conflict between the recipient's right to receive health care, as guaranteed by law, and the provider's right to be reimbursed at the Medicaid rate for the provision of services to recipients.

Of the nine States in the case study, Wisconsin was the only one to establish recipient safeguards against improper or excessive charging. All the others educated recipients through bulletins announcing the State's new cost-sharing program or changes in the existing program. Along with their Medicaid cards, Wisconsin sends recipients monthly notices describing cost-sharing amounts per service that were deducted as a result of claims submitted by providers. Recipients can then compare the charges against those they have paid to providers and seek recoupment from providers with the help of the Medicaid agency.

The third most administratively taxing aspect of starting and maintaining a copayments program is recipient participation. All of the nine States reported employing similar methods to introduce cost sharing to Medicaid recipients. Once the programs had been approved by the State legislatures, recipient bulletins were sent to recipients explaining the cost-sharing program. The program was also explained orally at the time of eligibility determination or redetermination. Any changes in the cost-sharing program

were also included in bulletins mailed to all recipients, with follow-up explanations at redetermination.

States reported that orientation to cost sharing for new eligibles was done both orally and in writing. During the eligibility determinations we observed in the three site-visit States, however, no mention of cost sharing (and only a passing word on the Medicaid program as a whole) was made by the caseworkers. This lack of information on cost sharing has led to confusion among recipients. Providers in the nine case-study States reported that newly eligible Medicaid recipients do not know they have cost-sharing responsibilities and often will not have the copayment with them or will refuse to pay it because they do not believe it is their responsibility.

What are the Short-Term Effects of Cost Sharing on Medicaid Expenditures?

Medicaid copayments are expected to contain expenditures in two ways--(a) by shifting service costs to recipients, thus lowering provider reimbursement payments by Medicaid, and (b) by lowering service utilization as a result of heightened recipient awareness of health care costs. In all the current programs except Arizona's, which is under a demonstration waiver, payments to providers for the services subject to cost sharing are reduced by the amount of the copayment. This cost shifting, a de facto rate decrease, produces immediate savings for Medicaid. As has been demonstrated in the private sector, most States also believe that cost sharing under Medicaid will decrease recipients' inappropriate service utilization.

Although the effects of cost sharing on expenditures were investigated in the nine case-study States, any conclusions are very limited. First, the data available from the States were limited. Second, the situation was complicated

by the implementation of other cost containment programs in the same period as cost sharing. For example, Nevada and Wisconsin instituted utilization controls on physician services and prescription drugs at the same time copayments were started on the same services. Nevada later instituted a prior authorization program. The assessment of cost-shifting is unaffected by these other initiatives but they do complicate the assessment of utilization change attributable to copayments.

Savings Due to Shifting Cost to Recipients. The measurement difficulties notwithstanding, it is clear that the majority of the short-term savings result from reduced reimbursement payments as opposed to reduced utilization. These savings are relatively easy to assess because they are based on the number of claims submitted. As shown in Table VII.3, the savings from cost shifting in the seven of our nine States with available data ranged from a high of 1.0 percent of total Medicaid expenditures to a low of .1 percent, with all but Kansas at .5 percent or below.

Comparing the per recipient savings helps to put these total Medicaid expenditures savings in perspective. Savings per recipient were highest in Kansas, at $15.81 in 1984; they were lowest in Maine, at $2.46.

As the right-hand columns in Table VII.3 illustrate, the amount of savings from cost shifting is related to the frequency of utilization, the amount of the copayments, and the number of services covered. Prescription drug services consistently produced the greatest savings from cost shifting, ranging from 80 percent of the total savings in Michigan (with copayments on 6 services), to 28 percent in Kansas with copayments on 10 services. The pronounced effects of copayments on prescription drugs stems from the high utilization rates for that service. More than twice as many prescription drug

Table VII.3

Savings Due to Cost Shifting
(States with available data)

State	Number of Services under Copayment	Savings	Savings per Recipient	Savings as a % of Total State Medicaid Expenditure	Service Producing Greatest Savings and Amount of Copayment	Percent of Total Savings	Service Producing Second Greatest Savings and Amount of Copayment	Percent of Total Savings
Wisconsin 1982	21	$3,285,180	$7.14	0.4%	Prescription Drugs $0.50	36%	Transportation $0.50 - $3.00	25%
South Dakota 1984	14	$300,000 - $350,000	$9.98	0.4%	(insufficient data)		(insufficient data)	
Iowa 1984	13	$1,578,776	$7.87	0.5%	Prescription Drugs $1.00	64%	(insufficient data)	
Kansas 1984	10	$2,490,558	$15.81	1.0%	Prescription Drugs $1.00	28%	Inpatient $25.00	24%
Nevada 1984	10	$143,401	$5.23	0.2%	Prescription Drugs $1.00	73%	Outpatient/ Mental $1.00	9%
Michigan 1984	6	$4,240,200	$8.63	0.3%	Prescription Drugs $0.50	80%	Vision $2.00	8%
Maine 1984	1	$300,000	$2.46	0.1%	Prescription Drugs $0.50	100%	n.a.	n.a.

SOURCE: State Documents and HCFA 2082 Data; see Beck et al., MPE Working Paper 6.1.

claims were submitted as for any other service. Even though the amount of the cost sharing per claim was low, the number of claims was high enough to produce the substantial savings.

The copayment amount also was an important factor in the amount of savings. Kansas, which had the greatest savings per recipient, had high copayments--$25 on the service producing its second highest savings from cost shifting, inpatient hospital admissions. In Wisconsin, although 21 services were subject to copayments and relatively few claims for transportation services were submitted, the relatively high amount of the transportation copayment, up to $3.00 per claim, as compared with the typical copayment of $1.00, produced 25 percent of the savings resulting from cost shifting.

Service Use. As noted, savings associated with changes in recipient utilization of services subject to cost sharing cannot be estimated with any confidence, due to the concurrent implementation of other cost-containment initiatives in most of the nine States. What information there is, however, does not suggest that cost sharing has much of an impact on recipient utilization of Medicaid services.

The best data are on the effects of copayments on use of prescription drugs. As shown in Table VII.4, in six States prescription drug utilization consistently declined during the year cost sharing was implemented. In each State with data, prescription drug use increased for the year following cost-sharing implementation, but only slightly. This pattern also seems to exist for other services. For example, in Kansas and North Carolina, where utilization data were tracked before and after the implementation of copayments, initial declines and subsequent increases were found in the use of physician, inpatient, dental, and chiropractic services. This corroborates previous

Table VII.4

Percentage Change in Prescription
Drug Utilization

State	% Change in Units Per Recipient		
	1 Year Prior to Cost Sharing	Year Cost Sharing Implemented	1 Year Post-Cost Sharing
New Mexico		-4%	
Kansas	-5%	-8%	+1%
Wisconsin		-18%	
Nebraska	+3%	-23%	
North Carolina	+24%	-17%	
Missouri		-18%	+1%

SOURCE: See Beck et al., MPE Working Paper 6.1.

research which has found an increase in utilization after an initial decrease brought on by the implementation of cost sharing.[1]

The nine case-study States reported no shifts in use among services--that is, no increase in one service due to decreases in another, cost-shared service; however, such perceptions cannot be taken as very good evidence even of short-term patterns and certainly cannot be interpreted as implying anything about the longer term.

Two States, Wisconsin and North Carolina, undertook analyses that provide some evidence on cost sharing's savings through reduced service utilization. In 1983, Wisconsin's Department of Health and Social Services completed a study of the impact of cost sharing on recipient utilization among both high and average users of Medicaid services. Three cost-shared services were compared with one non-cost-shared service.[2] Although other cost-containment initiatives were instituted on all four services at the same time as cost sharing, utilization of each of the four services was affected by these other initiatives in specific ways which could be observed. Thus, the effect of cost sharing could be isolated. Utilization reduction occurred in all four services, but the reduction for cost-shared services was twice as large as that for the non-cost-shared service. All recipients reduced their utilization, but high users decreased use by almost twice as much as the average users.

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1. J. D. Hantcin, D. Steinwacks, and C. Ellces, "The Impact on Utilization of a Copayment Increase for Ambulatory Psychiatric Care," Medical Care 18:807-815, 1980. See, also, Beck, op. cit.

2. "Preliminary Findings of a Review of the Medicaid Copayment Policy," Division of Policy and Budget, Wisconsin Department of Health and Social Services, March 1983.

North Carolina was somewhat different. In that State, copayments, the only cost-containment initiative, were established for medically needy physician and inpatient hospital services and on both categorically and medically needy dental services. Use of physician, inpatient hospital, and dental services was then reviewed. The results of the second-year analysis of physician and inpatient utilization showed a significant decrease for the medically needy (those subject to copayments) while categorically needy utilization (those exempt from copayments) increased. In contrast, dental services, subject to cost sharing among both the categorically and the medically needy, inexplicably showed a marked increase in utilization, 56 percent in the same year.

What Are the Effects on Recipients and Providers?

Recipients. The desired effect of copayments on recipients is to lower their unnecessary use of medical services, but not at the expense of health care quality and health status. As noted, some studies suggest that cost sharing does decrease utilization, but may also have negative consequences for recipients' health.

Findings from Wisconsin's cost-sharing study cited earlier suggest decreases in service use that could portend negative effects on health status. Two years of utilization history, pre- and post-cost sharing, were reviewed for services determined to be appropriate to the maintenance of good health (e.g., physician exams, dental exams). There was a 24 percent decline in utilization of those services among average users (although no change among high users), but no decline in the use of more episodic services. Whether decreased utilization of preventive services will lead to an eventual decline in the health status of Medicaid recipients remains to be seen, however.

A commonly cited inequity in current cost-sharing policy is the disproportionate financial burden placed on the noninstitutionalized disabled and aged under cost-sharing programs. In a position paper on recipient cost sharing, Washington's Division of Medical Assistance recommended rejection of cost sharing on this basis:

> In our view, copayments are neither a fair nor effective way to constrain Medical Assistance expenditures. Copayments are a regressive means of funding the Medicaid program because the people who require more care on the average, such as elderly people, chronically ill people, or disabled people, would have to spend a much higher proportion of their funds than younger or more healthy people. TEFRA increases this tendency by excluding children from the possibility of copayment requirements.[1]

Generally, the disabled and the aged are higher service users than other populations, but their higher rate does not necessarily indicate a pattern of excessive or unnecessary service use. They typically require more medical care. The underlying premise of cost sharing is to promote cost-conscious behavior by consumers, thereby cutting unnecessary utilization. Some providers and Medicaid officials in the nine case-study States believe that the disproportionate burden of cost sharing on the aged and disabled should be relieved since it is not consistent with the legislative intent of cost sharing. These recipients, although high users of services, are typically not inappropriate users of services. Cost-sharing legislation does not allow for exemptions other than those specified in Federal regulations, though.

Providers. One crucial question in assessing the effects of copayments on providers is whether it has led to a decrease in their participation in Medicaid. The nine case-study States reported no decline in providers

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1. "Position Paper: Recipient Cost Sharing for Medical Services," State of Washington, Division of Medical Assistance, October 26, 1982.

enrolled in Medicaid as a result of copayments. However, this finding may be deceiving because providers can be enrolled in Medicaid yet not serve any Medicaid recipients. The same Wisconsin study of Medicaid copayments found that six-month averages for provider enrollment before and after cost-sharing implementation showed a 17 percent increase in providers delivering cost-shared services. When actual services rendered per physician was measured for the same period, however, the number of providers rendering any service declined an average of 18 percent per service with copayments. Of the ten provider types subject to cost sharing in Wisconsin, providers of transportation services were the only group not to show a decline in services rendered. The Wisconsin findings, however, can only suggest a possible effect on provider participation (i.e., that some Medicaid providers render fewer services after cost sharing is instituted). Other factors, like a change in the number of providers available to meet the service need, or less recipient demand for services due to the deterrent effect of copayments, could easily explain the same observation. Definitive knowledge must await more rigorous statistical analysis.

Attitudes toward cost sharing among different types of providers varied in the nine case-study States. Pharmacists and, to a lesser degree, dentists, were reported to be the two most enthusiastic supporters of cost sharing. A possible explanation may be the relative ease with which both groups can collect copayments. Providers who are more likely to have to wait for receipt of copayments or not collect at all were typically less positive in their response to the implementation of cost sharing.

There appeared (based on the interviews) to be a clear division between institutional and noninstitutional providers regarding the collection of

copayments. Institutional providers, like hospitals, were less apt to collect them. One reason may be hospital practices, which include billing clients after the date of service, with the higher administrative costs associated with later billing. Hospitals reported that the cost of processing one bill ranges from $2 to $5, and most copayments are less than the cost of generating the bill. Given the fact that less than one-third of recipients respond to an initial billing, the subsequent collection costs further reduce hospitals' willingness to charge copayments to Medicaid recipients.

The pattern of responses across the nine States concerning providers' collection of copayments, was mixed. Some State respondents estimated, on the basis of comments and complaints from providers and other information, that most providers were indeed collecting copayments. Some States indicated they had been told by a small number of providers that they were either ignoring or having difficulty collecting the copayment. In one instance, small retail pharmacies complained of competitors, particularly large chains, who were not charging the copayment in order to attract Medicaid customers. On the other hand, providers, particularly pharmacies, in some States were reported to be requiring the recipient to pay the copayment prior to service delivery and, in the absence of payment, denying service provision, an apparent violation of Federal law.

These differences among States could be expected, in part, because States vary somewhat in their position on whether providers must actually collect the copayment from the recipient or, in part, because of differing attitudes toward Medicaid recipients. At least 16 States indicated, either in their provider manuals or bulletins and notifications, that collection of copayments was required. Others allowed provider discretion in the charging of

copayments based on the recipient's individual circumstances, but were very clear in forbidding discounts of the copayment for promotional purposes.

Even in States that required providers to charge and collect the specified copayment amount, there seemed to be little emphasis on monitoring compliance. In most cases, Medicaid staff checked on provider compliance only when complaints were received--usually from competitors.

Finally, many providers view cost sharing as an example of Medicaid's unfairness toward providers. The cost-sharing amount is automatically deducted from claims, regardless of the providers' success at collecting it. The result is a de facto reimbursement rate decrease. This feeling of unfairness was heightened with the passage of TEFRA. Providers understandably dislike the TEFRA provision that forbids them from denying care or services to an individual because of his or her inability to pay required cost-sharing charges. TEFRA's provision requiring a determination of recipients' ability to pay the cost-sharing charge is also cited as an example of the inequity in Medicaid's treatment of providers.

> In developing and implementing the policies and procedures which satisfy the requirement that providers may not deny services in situations where the recipient is unable to pay copayment charges, it is not a requirement that the State make determinations that the individual is unable to pay. Either the State or the provider may make the required determination. The determination should be based on guidelines developed by the State. The operating guidelines may apply the use of reasonable presumptions but must also permit circumstances in individual cases to rebut these presumptions.[1]

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1. Draft Memo Re: Determinations of Recipient Ability to Pay Cost Sharing - ACTION, Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administration, March 25, 1986.

Although some Medicaid officials in the nine case-study States suggested that the determination could be made by providers, the latter saw no point in determining a recipient's ability to pay since they are required to provide service regardless. The provision was viewed by many providers as one more duty to perform for their already low Medicaid reimbursement, a duty not required with their higher paying private sector patients.

What Is the Effect on Administrative Costs?

Administrative costs include three components: personnel, operations (primarily computer programming and servicing), and mailing charges for notifications sent to recipients and providers. Total administrative costs for copayments represent 0.01 to 0.1 percent of total Medicaid expenditures in any given State according to Medicaid administrators in the nine States reviewed.

Each of the nine States reported that start-up administrative costs were expensive compared to continuing administration costs, yet few States were aware of the actual start-up costs. In the three States where start-up costs were reported they ranged from a high of $148,400 in North Carolina to a low of $30,000 in Iowa. Nevada spent $3.55 per recipient, North Carolina $0.44, and Iowa spent $0.17 per recipient on administrative costs. This range of administrative cost per recipient probably reflects, in part, the number of copayment services: eleven for Nevada, twelve for North Carolina, and seven for Iowa.

Computer system changes were reported by all nine States as the most costly component of copayment program start-up. Procedures to assure that appropriate enrollees and services are involved and that copayment charges are correct must be programmed into the claims processing system. According to

the States we reviewed, programming changes were necessary at many points in the computer system. One State found the TEFRA requirements so costly that they have not complied with all the mandated changes; and if they were forced to comply, they would drop their cost-sharing program rather than bear the computer system change costs of achieving full compliance.

States reported minimal administrative costs for ongoing maintenance of copayments; however, when changes in services or recipient groups affected by copayments had to be implemented, such as TEFRA required charges, costs were at similar levels to those incurred at the initial implementation of cost sharing. With the exception of North Carolina, the study States did not account for the computer time required for routine operation--such as deducting the copayment and monitoring exemptions--or the cost of personnel to monitor the system. North Carolina estimated continuing administrative costs at a very low $2,000 annually.

Summary

The fourteen years of experience with cost sharing in Medicaid evidences some findings about the type of cost sharing employed, the impact of Federal legislation on the use of cost sharing, and some limited findings on service expenditure effects. The impact on recipients, providers, and over-administration remains somewhat unclear, in part because States generally have not evaluated their cost-sharing initiatives. States attribute the lack of full-scale evaluation activity to: (1) insufficient funds and/or competing requests for the limited available evaluation funds; (2) the ability of States to demonstrate decreased outlays by simply counting the number of units of service affected through cost shifting; and (3) the complexity of in-depth evaluation due to concurrently implemented cost-containment measures.

Among the three types of cost sharing--deductibles, coinsurance, and copayments--copayments are the choice of almost all Medicaid programs. The use of cost sharing in the form of copayments has been a State option since Medicaid began in 1965. The first States adopted cost sharing in 1973, following legislation changing the copayment basis from an income-related to a nominal payment which could be imposed, at State option, for optional services provided to both categorically and medically needy recipients and mandatory services for medically needy recipients.

Although additional legislation was passed in the interim, it was not until the 1982 TEFRA legislation that cost-sharing provisions were significantly altered. TEFRA altered the cost-sharing legislation by specifying a list of services (not all optional) and recipients that could be included and by allowing cost-sharing charges for the categorically needy on most mandatory services. The administrative complexity of those provisions is cited by several States as the reason they dropped cost sharing.

A review of the cost-sharing experience in the 35 States that have tried it, preliminary case studies of the experiences of nine States, and three detailed case studies were undertaken to learn more about the effect of copayments--the dominant form of cost sharing under Medicaid--on providers, recipients, and Medicaid administration. It is not clear what effects cost sharing has had on providers. For those whose services are generally purchased at the time of supply (such as pharmacists), and who can charge copayments at that time, the burdens of cost sharing are relatively limited. For providers whose invoices are generally paid after the receipt of service (such as hospitals), cost sharing includes the prospect of not recovering the copayment in addition to the administrative burden. The frequency with which

providers charge and collect copayments and cost-sharing's impact on provider participation in Medicaid remains unclear.

Of the seven case-study States with data, the savings to Medicaid from shifting costs to recipients seem to be in the range of $2.50 to $15.50 per recipient per year. Prescription drug services consistently produced the greatest savings from cost shifting. The pronounced effects stem from high prescription drug utilization rates (i.e., each time a recipient purchases a prescription drug, the copayment amount is shifted to the recipient, thereby relieving Medicaid of a portion of the cost).

No data were available to permit rigorous estimation of possible effects of cost sharing on recipient utilization of Medicaid services. What evidence States had compiled was mixed. States did have limited data on their costs. They reported that start-up administrative costs--costs for initial implementation--are high. The administrative costs of an ongoing program are much lower, but the costs of implementing legislative or regulatory changes approach the costs of initial implementation.

The question still remains as to the full and long-term effects of cost sharing. There is preliminary evidence that cost sharing may save more in the short run than it saves over the long run. If cost sharing reduces preventive service use in a manner that causes subsequent use of high-cost services occasioned by foregoing earlier treatment, it may not produce savings in the long run.

VIII. HOME AND COMMUNITY-BASED CARE WAIVERS

Growing numbers of low-income elderly and disabled Americans and escalating Medicaid nursing home expenditures prompted the Congress to enact Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). This section of the Act authorized the Secretary of DHHS to grant waivers to States permitting Medicaid reimbursement for certain home and community-based health and social services to Medicaid eligibles who, but for the waiver services, would resort to care in a nursing home or other institutional setting. The target populations for the legislation were the low-income elderly, severely physically disabled, and the mentally disabled such as the mentally retarded or chronically mentally ill.

Section 2176 waivers encourage States to reform their long-term care systems by eliminating the historical Medicaid bias toward institutional care. The waiver enables States to equalize eligibility options for home and institutional settings and to offer certain non-medical services not normally covered by Medicaid. States can define target groups for the waiver in terms of the frail elderly, physically disabled, and developmentally disabled.

This chapter summarizes findings presented in Robert Clinkscale and James Vertrees, "Evaluation of Medicaid Section 2176 Home and Community-Based Care Waivers," MPE Working Paper 1.10; Susan Laudicina and Brian Burwell, "Profile of Medicaid Home and Community-Based Care Waivers," MPE Working Paper 1.4; Robert Clinkscale and Joshua Pollatsek, "Evaluation of the California In-Home Medical Program," MPE Working Paper 1.6; James Vertrees and Kenneth Manton, "Evaluation of the California Multi-Purpose Senior Services Waiver Program," MPE Working Paper 1.5; James Vertrees and Kenneth Manton, "Evaluation of the Georgia Alternative Health Services (AHS) Medicaid Waiver Program," MPE Working Paper 1.7; Brian Burwell and Portia DeFilippes, "Evaluation of the California Developmentally Disabled Services (DDS) Waiver," MPE Working Paper 1.3; James Vertrees and Robert Houchens, "Waiver Impacts on Medicaid Nursing Home Use and Expenditures", MPE Working Paper 1.9.

Target groups can further be restricted to sub-State geographic areas and specific service coverage.

In their applications for Section 2176 waivers, States are required to project program caseloads, estimate the per capita costs of serving program clients, and show expected impacts on nursing home utilization and expenditures. States must show that the additional costs of waiver services will be offset by reductions in nursing home expenditures, i.e., be budget neutral to Medicaid. The first Section 2176 waiver granted by HHS was to the State of Oregon in December 1981.

This chapter summarizes the status and provides preliminary findings on the effects of Medicaid Section 2176 home and community-based care waivers. These findings mark year three of a four-year evaluation effort. Specific evaluation questions include:

- How have States implemented the waivers?
- To what extent have States successfully targeted the waivers to those who otherwise would have been in institutions under Medicaid?
- Have the waivers lowered aggregate Medicaid long-term care expenditures?
- Have additional costs to other Federal programs (such as Medicare or SSI) resulted from the use of the waiver?
- Do the waivers provide appropriate services, adequately monitored?
- What are the attributes of successful waiver programs?

Data Sources and Methodology

The scope of the evaluation includes national, State, and individual levels. At the national level, the emphasis is on documenting the way States have used their waiver authority and their progress toward implementation.

Data for national descriptive statistics on all waiver programs as of certain cutoff dates were gathered by an annual survey of all State waiver programs conducted for this evaluation. National descriptive statistics on waiver programs were also taken from State annual waiver reports to HCFA (Form 372). Multiple regression analysis was used to detect any reductions in the rate of increase in State and national Medicaid nursing home use and expenditures that may be reasonably attributable to the waiver programs. Data used for this purpose came from the HCFA-2082 annual statistical reports.

State-level analyses supplemented the national studies through case studies of selected programs. Waiver programs covered by the case studies reported here include: California Multi-Purpose Senior Services Program (MSSP), California In-Home Medical Care (IHMC) Program, Georgia Community Senior Services Program (CSSP), and the California Developmental Disabilities (DDS) Program. The case studies represent a cross-section of major waiver populations including the frail elderly, the physically disabled, and the developmentally disabled.

These four waivers were selected for early analysis because the programs were well developed, data were available, and the States expressed a willingness to support the case studies. Several visits were made by evaluation teams to each case study site to learn about program administration, targeted populations, services provided, quality assurance mechanisms, and screening and assessment criteria. Person-level data for the case studies was taken from HCFA's Medicaid tape-to-tape and the Medicare MADRS files.

In all cases the availability of data on strength of informal support was very limited. Since strength of informal support is a key determinant of risk

of institutionalization, our analyses of the risk determinants of institutionalization is incomplete. Data on the use of other public support programs such as Medicare, SSI income security, and block grant social services programs were likewise limited.

What Are the Characteristics of the Waiver Program Nationally?

Geographic Coverage and Enrollment Levels. Survey results as of September 30, 1985 indicate a high degree of interest among States in the waiver program. This interest is high in all geographic areas of the country for both the aged/disabled (A/D) and the developmentally disabled/chronically mentally ill (DD/CMI) target groups. Figures VIII.1 and VIII.2 show maps of waiver geographic coverage. There were 75 programs in 42 States by the end of FY 1985, compared with 67 one year earlier. Current applications to HCFA for new waivers and renewals of existing ones indicate that the popularity of Section 2176 is not only sustained but growing.

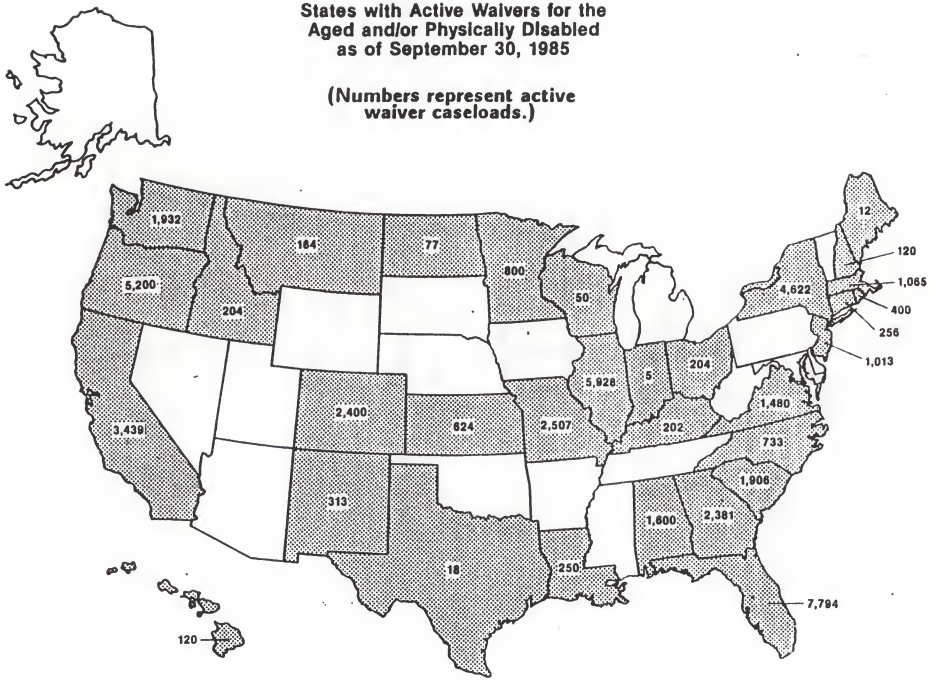
Among the 42 States, 34 waivers were targeted exclusively to the A/D population while 35 served the DD/CMI group. Six waivers served a combination of both general target groups. By DHHS regulation, new combination programs are no longer permitted. All new waivers are to be population-group specific. From start-up to September 30, 1985 approximately 125,000 people have been served by the waivers; about three-quarters of these were A/D and one-quarter DD/CMI. That is, the enrollment to date for the A/D groups was about 92,000 compared to 33,000 for the DD/CMI groups.

The growth of the program since 1982 has been dramatic, as indicated by the annual recipient count shown in Table VIII.1. As of September 30, 1985 over 70,000 people were being served by the waiver programs. Programs for the

FIGURE VIII.1

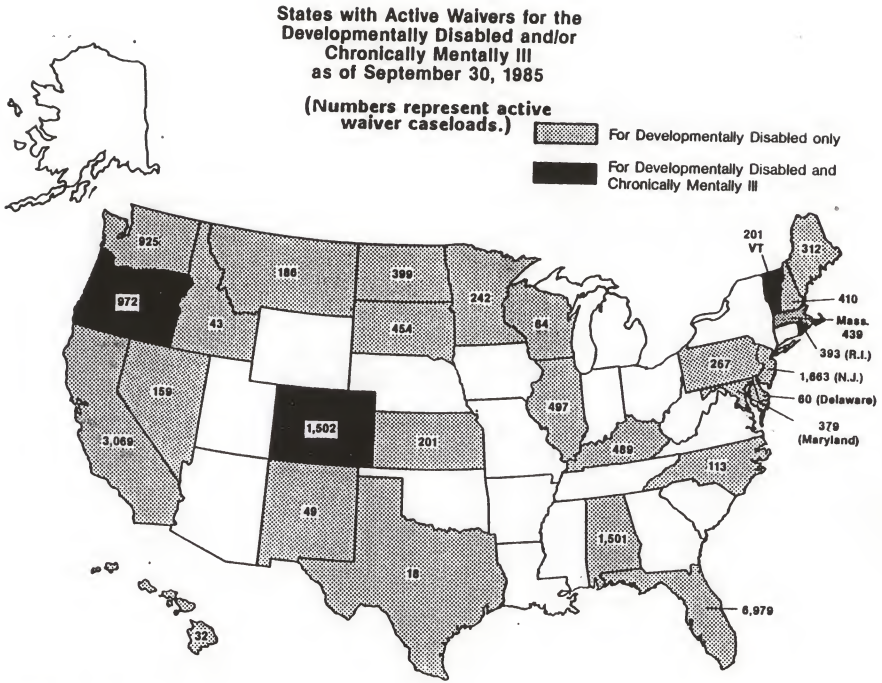
States with Active Waivers for the Aged and/or Physically Disabled as of September 30, 1985

(Numbers represent active waiver caseloads.)



Source: La Jolla Waiver Survey (1985)

FIGURE VIII.2



Source: La Jolla Waiver Survey (1985)

Table VIII.1

Growth in Waiver Recipients, by Target Group

	A/D	DD/CMI	Total
1982	6,389	10,253	16,642
1983	31,735	16,365	48,100
1984	45,934	21,823	67,756
1985 (Sept. 1985)	47,819	22,218	70,037

SOURCE: La Jolla Waiver Survey, 1985. (MPE Working Paper 1.10.)

A/D groups account for two-thirds of the total active caseload; DD/CMI individuals for the other third (of which only 1,109 were CMI individuals). This breakdown is not surprising given the larger number of the elderly in the Medicaid population.

The average waiver program size is 1,195 for A/D and 542 for DD/CMI. However, States vary widely in the size of their programs. Florida and Illinois have the largest A/D waivers; Florida and California have the largest DD/CMI waivers. Five States (Florida, California, Illinois, New York, and Oregon) represent 56 percent of the national A/D caseload; five (California, Alabama, Colorado, Florida, and New Jersey) account for 66 percent of the DD/CMI caseload.

Turnover rates for A/D waiver recipients are considerably higher (about 50 percent per year) than for the DD/CMI group (20 percent). About one-quarter of the A/D group leave the waiver program before six months, whereas half of the DD/CMI recipients were still in the waiver program after two years. This reflects higher mortality and nursing home entry rates for the A/D population. Individuals in the DD/CMI group may spend most of their lives outside institutions due to the availability of home and community-care services. Some observers attribute this to the strength of the residential care system already well established in many States prior to the Medicaid waivers.

As of late 1985, although 70,000 individuals were being helped by waiver services, their numbers in terms of the Medicaid long-term care population were still relatively low. The penetration rate (ratio of waiver recipients to nursing home residents plus waiver recipients for the A/D population, for example, was only 4 percent overall. Only four States had rates above 10

percent (Florida 17.1 percent, Colorado 14.0 percent, South Carolina 13.0 percent, Oregon 29.9 percent). The penetration rates for the DD population were higher--averaging 23 percent and ranging from a low of 2.7 percent in Wisconsin to a high of 68.4 percent in Florida. Almost one in four of the waiver-eligible DD population in waiver States thus are recipients of waiver services.

Client Characteristics. The A/D and DD/CMI target groups have different characteristics (these data are from the 1985 La Jolla survey of State waiver programs, MPE Working Paper 1.4). In general, numbers of the A/D population tend to be slightly younger than their counterparts in nursing homes, although equally impaired in terms of health and functional dependency. The DD/CMI group is dominated by the mentally retarded, but the level of retardation is not as severe as the level of those living in institutions. Most waiver recipients become eligible for waiver services while living in the community; deinstitutionalization is rare for State programs serving the A/D; it is somewhat higher for DD/CMI clients entering waiver programs from an ICF-MR or other State institutional setting. The emphasis in the waivers is not, therefore, to deinstitutionalize people; rather, they are used by States to avoid or to delay institutionalization.

Four-fifths of the A/D waiver population is 65 years of age or older; one-fifth is 85 or above. Most are female (75 percent) and live in a private residence. The great majority (83 percent) of the A/D population entered the waiver program from a private residence; only 2.4 percent entered from nursing homes. Eighty percent are either widowed, divorced, or separated. The DD/CMI population is much younger, between the ages of 22 and 39, and the majority are male (55 percent).

The health and functional status of A/D recipients is generally poor. About 37 percent suffer from circulatory diseases, 10 percent nervous disorders, 14 percent cancers, and 10 percent have musculoskeletal disorders. Five percent of A/D recipients have mental disorders as a primary diagnosis. Approximately 45 percent are incontinent. This health status profile corresponds to that of nursing home residents with the exception that the incidence of mental disorders (usually cognitive impairment or senility) is much higher for nursing home residents (20 percent of the nursing home population).

The DD/CMI population is composed primarily of mentally retarded individuals. These waiver recipients do, however, differ substantially from their age cohorts living in ICF-MR facilities. Mildly and moderately retarded persons account for only 22 percent of the ICF-MR population, but 53 percent of the waiver population. Severely retarded persons constitute a somewhat higher proportion of waiver recipients (30 percent) than ICF-MR recipients (25 percent). Profoundly retarded persons accounted for over half of the ICF-MR population in 1982, and only 17 percent of the waiver population in 1985. This distribution of waiver recipients by level of retardation suggests that waiver recipients are less impaired than the ICF-MR population. This is logical since one would expect the waiver program to concentrate on individuals who function well enough to enable them to be served equally well in the community. Less than one-third of DD/CMI recipients enter the waiver programs from institutional settings; most are already in private or group settings.

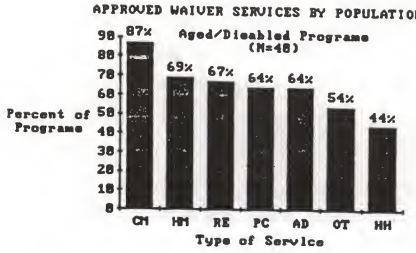
Service Utilization. The Section 2176 legislation allows States considerable flexibility to decide what services to offer and how to define

those services. The survey asked States to indicate which services were approved by HCFA under their individual waivers during Federal FY 1985. The results are shown in Figure VIII.3.

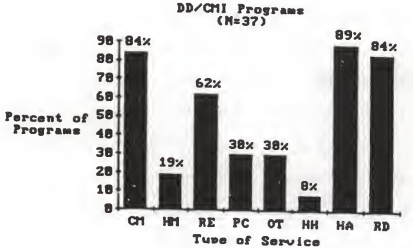
Obvious differences appear between A/D and DD/CMI waivers concerning the relative importance of specific home and community-based services. In structuring their A/D waiver programs, States as a whole reveal the following ranking of service priority: (1) Case Management, approved in 87 percent of the programs; (2) Personal Care, Homemaker, Respite and Adult Day Health Care, approved in 60-70 percent of the programs; and (3) all other services, which are available in about half of the waivers. For the DD/CMI waivers, they follow a different ranking: (1) Habilitation, approved in 89 percent of the programs; (2) Case Management and Residential Services, available in 84 percent of the programs; and (3) all other services are available to lesser degree. As will be explored later in the chapter, the extent to which a waiver service is "approved" differs from the degree to which it is actually provided and reimbursed.

Case management comprises a number of client screening, assessment, and quality assurance activities. Generally speaking, it can be either broadly defined and reimbursed as a distinct waiver service, or more narrowly defined and included as a State administrative cost of operating their Medicaid program. Personal care and homemaker services are similar to each other in that they both include meal preparation and general housework. Personal care is normally done under the auspices of a physician's plan of care and can include assisting the client with personal grooming and bathing. Respite care is provided to relieve the family and/or friends of waiver clients from their caregiving duties, and is usually offered for a period of hours or single

FIGURE VIII.3



Key:
CM = Case Management
HM = Homemaker
RE = Respite
PC = Personal Care
AD = Adult Day Health
OT = Other Services, including:
Habilitation, Medical Supplies, Skilled Nursing, Therapies, Meals, and Transportation.
HH = Home Health Aide



Key:
CM = Case Management
HM = Homemaker
RE = Respite
PC = Personal Care
OT = Other Services, including:
Medical Supplies, Skilled Nursing, Therapies, and Transportation.
HH = Home Health Aide
HA = Habilitation
RD = Residential Services

Source: La Jolla Waiver Survey (1985)

days. Adult day health care denotes a variety of health and social services provided in a residential group setting. Habilitation is a generic term for a broad array of developmental training services tailored to the needs and disabilities of individuals so that they may function with greater independence. A large portion of habilitation expenses pays for residential care staff who supervise the home. Various types of training are conducted under the rubric of habilitation services, depending on the level and types of client deficiencies, and their established goals and objectives.

Expenditures. Total Federal and State expenditures for the waiver program from FY 1982 through FY 1985 are provided in Table VIII.2. Based on HCFA's report that fourth quarter FY 1985 waiver expenditures were $85 million, total annualized expenditures for the waiver program will approach $400 million in FY 1986. The annual rate of growth of the program between FY 1984 and FY 1985 was nearly 40 percent. As can be seen, more of the total expenditures go for the DD/CMI population than the A/D population, even though the DD/CMI group represents only one-third of all recipients; the cost per recipient is much higher ($7,259 versus $2,008).

Figures VIII.4 and VIII.5 provide a distribution of expenditures across the various waiver services for each of the two target populations. More than half the waiver expenditures (55 percent) for the A/D population were for homemaker and personal care services; most of the DD/CMI expenditures (77 percent) were for habilitation and residential services.

The hourly cost for A/D case management services ranges from a low of $7 in West Virginia to a high of $43.84 in Connecticut. This wide range reflects different State views on the nature of case management services. A/D personal care cost per hour ranges from a low of $3.85 in Montana to a high of $14.84

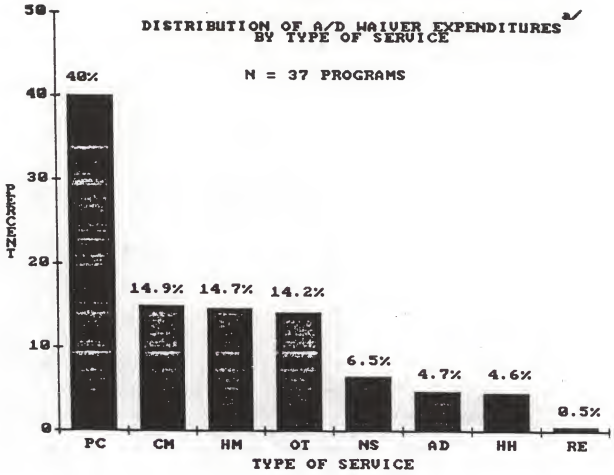
Table VIII.2

Waiver Expenditures, by Target Group
FY 1982-85

	A/D	DD/CMI	Total
1982	$ 596,589	3,055,314	3,651,903
1983	$ 19,518,626	60,638,320	80,156,947
1984	$ 61,788,640	119,302,729	181,091,369
1985	$ 96,015,448	161,273,676	257,289,124

SOURCE: For FY 1982, 1983, 1984, HCFA Form-64 data; for FY 1985, LaJolla Waiver Survey (1985). (MPE Working Paper 1.4.) 1985 data on waiver expenditures do not include six waiver programs which were unable to provide expenditure data on the survey.

FIGURE VIII.4



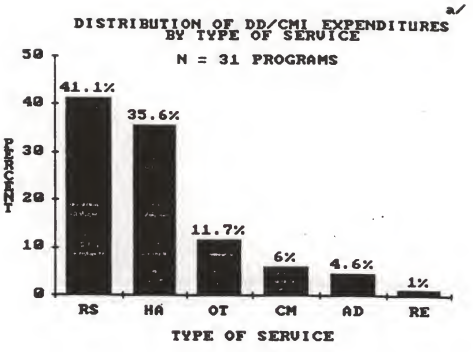
Total A/D 1985 Expenditures = $96,015,448

Personal Care	=	$38,412,541
Case Management	=	$14,264,464
Homemaker	=	$14.066,974
Other Services	=	$13,612,023
Not Specified	=	$ 6,234,773
Adult Day Health	=	$ 4,522,897
Home Health Aide	=	$ 4,447,403
Respite	=	$ 454,373

a/ Expediture data are for each waiver service delivered during the period 10/1/84 - 9/30/85. For several States the timeframe reported is slightly different. In the oase of Oregon, expenditures reported were for calendar year 1983. Massachusetts was unable to respond.

Source: La Jolla Waiver Survey (1985)

FIGURE VIII.5



Total DD/CMI 1985 Expenditures = $161,273,676

Residential	=	$66,307,884
Habilitation	=	$57,443,045
Other	=	$18,888,130
Case Management	=	$ 9,680,520
Adult Day Care	=	$ 7,403,902
Respite	=	$ 1,550,195

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a/ Expediture data are for each waiver service delivered during the period 10/1/84 - 9/30/85. For several States the timeframe reported is slightly different. The following States were unable to respond: Colorado (1 of 2 programs), Florida, Massachusetts, Minnesota, and Vermont.

Source: La Jolla Waiver Survey (1985)

in Kentucky. The cost per day for all A/D waiver services averaged $16.28--as opposed to $41.96 per day for the institutional alternatives (ICF and SNF care). The cost per day for all DD/CMI services averaged $45.05--as opposed to $93.84 per day for ICF-MR care.

Eligibility Options. As noted earlier, there are three major client groups eligible for services under the Section 2176 waiver. They are: (1) the aged and/or disabled, most often defined by the States as over 65 years of age; (2) the developmentally disabled or mentally retarded of all ages; and (3) the chronically mentally ill of all ages. In addition to these categories, States have exercised several options in defining Medicaid eligibility. In more than half of all waiver programs, states have requested the right to provide different types of services in different regions of the State (waiver statewideness); to exclude deeming of the income of parents for persons 18 years or younger or a spouse in determining eligibility; and to deny waiver services on a case-by-case basis if they would be more costly than institutional services. In 29 waiver programs, States have elected to extend eligibility to the medically needy. About half of the State waivers incorporate the SSI "300 percent" option to extend eligibility for the waiver to those not eligible for SSI cash payments.

Administration. State waiver program administration varies widely among States. While lead agency responsibility is undertaken by a variety of public agencies, one pattern is clear: the entity most often cited as directing A/D programs is the State Medicaid agency, and the entity most often cited as being in charge of DD/CMI programs is the State Mental Retardation or Developmental Services agency. Lead agency responsibility has almost always been placed with a single entity.

A different pattern emerges, however, at the level of case-management and since delivery. Authority is much more diffuse, having been delegated by the lead agency to more than one agency in the majority of waiver programs. For example, Illinois operates one of the largest A/D waiver programs in the country, and reports that the following four public agencies are reimbursed under the waiver for the provision of such administrative services as case management, assessment, and quality assurance activities: (1) the State or local health department; (2) the State or local human services agency; (3) the local agency on aging; and (4) another State agency. Three of these entities are responsible for the hiring and supervision of case managers for waiver clients.

What Is Known About the Potential for Cost Savings Through 2176 Waivers?

HCFA Form 372 Data. As a condition of receiving a waiver States must agree to provide annual statistical reports to HCFA. The HCFA Form 372 is used for this purpose and requires States to report annual data--such as unduplicated number of waiver service recipients by type of service, days of waivered service use by type of service, total waiver expenditures by type of waiver service, and total Medicaid expenditures for waivered and non-waivered institutional populations. Due to early confusion over reporting definitions and the inability of some States to accurately complete the HCFA Form 372, analysis of these data is considered very preliminary. As of May 1986 HCFA had received and approved only 18 of the second-year waiver reports although there were at least 45 waivers well beyond the second year of operation. Table VIII.3 presents data for these 18 waiver programs. Based on a tabulation of the data available on the 18 second-year waivers, the following findings are offered.

Table VIII.3

Comparison of Total Medicaid Expenditures on Waiver Recipients to Total Medicaid Expenditures on Non-Waiver Institutional Recipients

Second Waiver Year

Waiver Program Type	Total Medicaid Expenditures[a]		Expenditures Per Recipient		
	Waivered	Non-Waivered Institutional	Waiver Recipients	Non-Waivered Institutional	Difference
Aged and Disabled					
Colorado 0006	9,681,212	114,038,473	4,307	8,360	4,053
Georgia 0012	10,165,742	267,824,222	4,359	7,983	3,624
Illinois 0015	54,639,059	509,526,846	4,763	8,183	3,419
Kentucky 0020	-	-	-	-	-
Minnesota 0025	5,327,305	482,536,811	5,306	12,935	7,629
Missouri 0026	2,014,518	186,149,940	1,846	7,995	6,149
New Jersey 0032	-	-	-	-	-
New York 0034	-	-	-	-	-
North Carolina 0035	1,809,802	228,545,894	6,262	10,183	3,921
North Dakota 0054	-	-	-	-	-
Rhode Island 0040	2,180,487	84,167,465	4,990	9,189	4,199
Texas 0045	-	-	-	-	-
Virginia 0048	2,630,320	190,529,814	3,752	9,948	6,196
Subtotal	88,448,445	2,063,319,465	4,519	9,345	4,826
Mentally Retarded and Developmentally Disabled					
Alabama 0001	7,265,282	49,574,221	4,281	34,284	30,002
Colorado 0007	15,540,600	142,292,466	13,963	11,775	(2,185)
Delaware 0009	-	-	-	-	-
Kentucky 0019	8,594,273	38,435,016	17,292	31,096	13,804
Maine 0022	-	-	-	-	-
Maryland 0023	-	-	-	-	-
Nevada 0030	2,940,064	33,366,831	7,084	12,634	5,550
New Hampshire 0053	-	-	-	-	-
New Jersey 0031	13,563,447	163,842,808	10,894	38,590	27,696
North Carolina 0036	-	-	-	-	-
North Dakota 0037	-	-	-	-	-
Pennsylvania 0039	-	-	-	-	-
Pennsylvania 0058	-	-	-	-	-
South Dakota 0044	4,022,632	15,695,059	8,802	22,746	13,944
Wisconsin 0052	-	-	-	-	-
Subtotal	51,926,298	442,406,401	9,573	19,820	10,247
Combined Programs					
Florida 010-011	30,178,453	355,500,588	3,623	9,668	6,044
Kansas 0018	-	-	-	-	-
Montana 0029	3,206,817	55,952,554	9,404	11,518	2,113
Oregon 0038	50,044,955	138,927,878	5,605	11,681	6,077
Washington 0049	9,493,009	178,285,004	5,063	NA	NA
Subtotal	93,463,234	728,666,024	4,763	9,729	4,966
TOTAL	233,837,977	3,234,391,890	5,241	10,170	4,930

Note: Non-waiver institutional recipients include all persons receiving at least one day of Medicaid-supported institutional care during the waiver year who did not receive any waivered services during that year.

a. Medicaid expenditures are reported for the waiver recipients and the non-waiver institutional recipients during the waiver year.

NA = The State did not make the data available in its 372-Form; (-) = No 372-Form.

Average annual total Medicaid costs per recipient for A/D waiver clients was $4,519, whereas for A/D individuals institutionalized during some portion of the year the average annual cost to Medicaid was $9,345--a difference of $4,826. For DD/CMI waivers the cost comparisons are $9,573 for waiver clients and $19,820 for cohorts experiencing nursing home or other institutionalization--a potential savings of $10,247 to Medicaid.

This line of reasoning assumes, however, that all waivered individuals would be members of the non-waivered institutional group without the waiver services. That is, these savings would be realized if client targeting were 100 percent effective. Given the difficulty of accurate prediction of who will enter a nursing home at any one time, the possibility of admitting people to the waiver who are not nursing home bound is great. The question is, how accurate does client targeting have to be in order for the waiver to still break even? Given the difference between annual Medicaid cost per recipient for waivered and non-waivered LTC recipients, it is possible to approximate a break-even point for each type of waiver program. This is the ratio of total Medicaid costs for waivered clients to total costs for non-waivered institutional clients, or about 48 percent for both A/D waivers and DD/CMI waivers (both ratios being 48 percent is a coincidence). This would mean that, on average, A/D waiver targeting could be wrong only 1 out of 2 times in order for the cost of waivered services to be offset the savings in nursing home costs; i.e., budget neutral to Medicaid. A 50 percent targeting efficiency may seem like a simple task for States to accomplish, but earlier HCFA-sponsored demonstrations, the recent HHS-sponsored National Channeling Demonstration Study and the case studies conducted during this evaluation study suggest that

this level of screening efficiency is highly unlikely. The expected accuracy of DD/CMI client targeting is a more complicated issue and, unfortunately, does not have the benefit of much prior evaluation research.

Aggregate State Program Data. Another approach to estimating the extent that the Section 2176 waiver programs reduce Medicaid LTC facility use and expenditures is to examine aggregate State program data. Two kinds of analysis are possible. First, spending could be compared for a single State before and after the waiver was implemented. This might be misleading because expenditures could be increasing or decreasing nationwide in response to other factors, reducing or enhancing the effect of the waiver. Alternatively, spending in waiver States during a particular year could be compared to spending in States that do not have waivers. The problem here is that factors related to prior or projected expenditure growth could be among the reasons that certain States sought waivers while others did not. The research design used for this study (MPE Report 1.9) attempts to control for these problems by pooling time series data across States.

In addition, there are factors that might preclude finding a waiver program effect even when it is present. For the A/D waivers, as noted, the penetration rate for the waivers is very low; A/D waiver recipients constitute only about 4 percent of the total Medicaid A/D population. This would make it difficult to detect waiver effects on institutional LTC utilization. In addition, if nursing home beds are in short supply, then the bed that would have been filled by a waiver service recipient will be filled by another Medicaid recipient. For the DD/CMI waivers the situation is different in that nursing home bed supply is not an issue and the penetration rate for these waivers is about 25 percent in States with waivers.

The results of the aggregate analysis of the A/D waivers was inconclusive. When States were assigned equal weights, no effect was evident. However, when States were weighted by program size, expenditures and expenditures per recipient grew (1983-85) more slowly in the non-waiver States, 3.3 percent versus 5.0 percent for expenditures and 2.8 percent versus 4.5 percent for expenditures per recipient. The difference in recipient growth rates between waiver and non-waiver States was about equal (0.3 percent versus 0.2 percent). There were no statistically significant differences between any of the waiver and non-waiver rates. Given the small penetration rates of the A/D waivers (4 percent) into the total Medicaid LTC population, the results of this analysis were expected.

The results of the aggregate analysis of DD waivers showed no reduction in ICF-MR recipients and expenditures in waiver States relative to non-waiver States through FY 1985. However, of the six waiver States which limited entry to the waiver to persons being deinstitutionalized directly from ICF-MRs (Hawaii, Pennsylvania, Wisconsin, Maryland, Delaware, and West Virginia), five (all but West Virginia) showed absolute reductions in ICF-MR recipients from the pre-waiver period. The rate of growth in ICF-MR expenditures was also less for these non-waiver States.

How Do the Waiver Programs Operate, and What Can Be Said About Their Cost-Effectiveness to Medicaid?

Four waiver programs were selected for intensive case study in order to learn more about how waiver programs operated and to examine, using person-level data, detailed characteristics of waiver populations and the extent to which the waiver programs are cost-effective to Medicaid. Case study evidence can provide valuable insight into what is happening under particular programs,

and is the only way to get at the issues directly. It cannot, of course, be generalized to all waiver programs.

Georgia Community Care Services (CSSP) Program. The Georgia waiver originated as the Alternative Health Services (AHS) demonstration program in 1976, serving an aged and chronically ill population throughout the State. The evaluation of the demonstration program found it to be lacking in client targeting; i.e., rates of nursing home entry for the treatment and control groups were found to be equal at 15 percent over the two year follow-up period. In reviewing Georgia's application for a 2176 waiver, HCFA expressed concern about the lack of the program's previous cost-effectiveness as a demonstration. Georgia proposed to improve client targeting by more carefully screening each applicant and capping waiver costs for each client at 75 percent of nursing home costs.

The CSSP became a waiver program effective October, 1981. Our case study (MPE Report 1.7) compared the experience of over 1,000 CSSP waiver recipients in late 1981 and 1982 with that of a community control group established for the earlier demonstration. Most of the waiver recipients were elderly black females, 20 percent were over the age of 85, and most suffered from multiple chronic functional impairments. All waiver recipients met nursing home admission criteria. Health status assessments were available on both groups, and Medicaid and Medicare claims data were linked to compare utilization and expenditure profiles. The average cost of waiver services in Georgia during 1982 was $172 per month compared with average monthly nursing home costs of $727. Our analysis matched waiver clients and controls on measures of demographic characteristics, health, and degree of functional impairment. Our findings regarding client targeting were somewhat encouraging in that

individuals enrolled in the waiver program had a 30 percent chance of entering a nursing home during the waiver period (30 percent of the control group enter a home). This percentage is much higher than the 2.5 percent found in the California MSSP study. However, additional findings show that the waiver services were not useful in delaying nursing home entry; i.e., since both waiver and controls were equally likely (30 percent) to enter a nursing home, there were no offsetting savings in nursing home expenditures. Therefore, the cost of Georgia waiver services were an add-on to Medicaid.

California Multipurpose Senior Services (MSSP) Program. The MSSP program serves an elderly, sick, and functionally impaired population of Medi-Cal recipients. Most of the MSSP recipients were elderly white females. Clients must be certifiable for nursing home care in order to enter the waiver program. The program began in 1980 as a demonstration project and converted to a 2176 waiver in 1983. During 1985, 3,944 people were served. Person-level data were obtained for client and control groups regarding Medi-Cal expenditures, Medicare costs, and functional and health status. Functional and health variables were used to control for differences between treatment and control groups in the risk factors that influence nursing home use.

The study (MPE Report 1.5) found that MSSP services cost less than nursing home care--$350 compared with $1,144 per month in FY1984. Thus, the program must correctly substitute a day of waiver care for a day of nursing home care 30 percent of the time in order to break even or be budget neutral to Medicaid. Our statistical analysis found that only 2.5 percent of MSSP clients would have entered a nursing home in the absence of the waiver (client targeting) and for those who would have entered a home, the MSSP services delayed or prevented nursing home entry in less than half of the cases

(service efficacy). The MSSP was not targeted to persons at extremely high risk of nursing home entry, and when targeting was correct, the waiver services did not prove to be good substitutes for nursing home services.

California In-Home Medical Care (IHMC) Waiver. This waiver targets in-home nursing services to severely disabled individuals who are often ventilator dependent small children at high risk of long-term hospitalization. Most recipients are extremely ill, often comatose. Mortality accounts for most program terminations. Retardation is prevalent for the target group due to brain damage at birth. During 1982 there were about 115 recipients in the waiver program. California's waiver application projected Medi-Cal savings approaching $15,000 per recipient per month since hospital costs were $30,000 per month and the cost of in-home nursing services were projected to be $15,000 per month. At the same time, the in-home nursing would enable the recipient to live at home with family instead of at the hospital.

Our evaluation design (MPE Report 1.6) involved a simple comparison of Medi-Cal expenditures 3-6 months before and after entry to the waiver program for a sample of 19 recipients out of 70 IHMC recipients in the second waiver year (July 1, 1984 - June 30, 1985). The sample represented all those recipients who had complete pre and post claims histories during the analysis period and is regarded as representative of typical waiver recipients. The average cost of waiver services was found to be $218 per day, mostly to pay for 16-hour nursing services. Average total Medi-Cal expenditures (including waiver and non-waiver costs) before waiver entry were $10,138 per month, compared to $12,125 after entering the waiver program. This is a very different outcome than projected in the waiver application. Based on the sample examined it would seem that the level of hospitalization prior to

waiver entry was much lower than projected and, unexpectedly, the level after entry was higher. Twelve of the 19 recipients in the sample had monthly Medi-Cal costs of less than $5,000 in the pre-waiver period. This reinforces the finding that substantial numbers of waiver recipients were already living at home during six months prior to waiver entry rather than at hospitals.

The average increase in Medi-Cal costs after waiver entry was not, however, found to be statistically significant due to high variances in the cost data. The findings do suggest that contrary to expectations, the IHMC waiver program probably does not result in the savings to Medi-Cal projected in the waiver application. Our qualitative review of the program suggests that quality of care for the homebound recipients is excellent.

California Developmentally Disabled Services (DDS) Waiver. The study (MPE Report 1.3) used a pre-post evaluation design. The study population included all persons who received DDS waiver services in 1983, a total of 594 individuals. For the cost study, only those waiver recipients who were also enrolled in Medicaid in 1981 (prior to implementation of the waiver), who used at least one Medicaid-covered service in 1981, and for whom 1983 Medi-Cal data were available were selected. The sample thus included a total of 488 developmentally disabled persons who were both Medicaid recipients in 1981 and waiver recipients in 1983. The study compared the costs of a cohort of waiver clients in 1983 to the costs of serving them before they were enrolled in the waiver (1981). Detailed claims for waiver services from DDS were linked with Medi-Cal claims files for non-waiver services to construct a complete record of Medicaid utilization and expenditures for the study sample in 1981 and 1983. Person-level data on spend-down liability amounts were used to estimate impacts on Federal SSI costs.

Prior to the waiver in 1981 most of the eventual DDS waiver recipients lived in the California State hospital system, reimbursed by Medi-Cal at ICF-MR rates. Hence, in 1981 the average annual cost to Medicaid, annualized to a full year of Medicaid coverage and inflated to 1983 dollars, was $29,414 as compared to $8,699 in 1983. About $7,000 (80%) of the $8,699 was for DDS waiver services, the remainder representing non-waiver Medicaid service costs. Thus, the DDS waiver clearly demonstrates that it can be much less expensive to care for the mentally retarded in residential settings than in relatively expensive ICF-MR institutions. This is true even when increased Federal SSI costs are considered.

On the surface, this pre-post data would appear to indicate that a savings of $10 million had accrued to Medicaid. However, we found that most of the waiver recipients had been deinstitutionalized well prior to their entry into the waiver program as part of an ongoing statewide effort to transfer mentally retarded patients to a system of State-funded residential care. Thus, it can be argued that potential savings to Medicaid is attributable to the deinstitutionalization program rather than the waiver. The cost of waiver services would then be equivalent to an increase in Medicaid spending and a savings to the State.

An additional finding is that the potential $10 million savings to Medicaid at the person-level was probably never realized at the overall Medi-Cal level. Although the number of persons in State institutions declined by 12 percent between 1981 and 1985, the average per-person institutional cost increased by 40 percent. Although Medicaid bought fewer days of ICF-MR care, increases in the cost per day appear to have more than offset the potential savings; i.e., overall ICF-MR spending increased. When occupancy rates fell,

the State continued to operate the institutions at about the same cost, and higher costs per patient day were passed on to Medicaid. Our overall conclusion is that it is implausible that the waiver was budget neutral to California's Medicaid program.

Summary

Home and community care waivers are very popular with the States. By September 30, 1985 there were 75 distinct waiver programs in 42 States: 34 were targeted to the aged/disabled population; 35 served developmentally disabled and chronically mentally ill (DD/CMI) individuals; and 6 programs served combined populations (A/D-DD). There were 70,000 waiver recipients in September 1985, one-third of whom were developmentally disabled and two-thirds were aged and/or physically disabled. Only 1,100 of the DD/CMI caseload were chronically mentally ill. Five States represented 56 percent of the national A/D caseload; five States accounted for 66 percent of the DD/CMI caseload. Of the $257 million in Medicaid funds spent on waiver services in FY 1985, approximately 63 percent was for the DD/CMI population, although this group represents only one-third of all waiver recipients nationally. The average annual cost per DD/CMI client is about $7,259, compared with $2,008 per A/D recipient.

The waiver programs have not deinstitutionalized significant numbers of people, since most recipients enter the waivers while already living in the community. Only 2.4 percent of the aged and disabled recipients entered the program from nursing homes and only one-third of the DD/CMI population entered the waiver from ICF-MRs or other state institutions. Many waiver programs qualify individuals for entry based solely on their criteria used for nursing home level of care. Medicaid nursing home entry medical criteria are not, by

themselves, sufficient to effectively limit waiver entry to only those individuals who, but for the waiver services, would in fact elect to enter a nursing home. Almost half of the impaired elderly over 75 years of age and most of the developmentally disabled living in the community at large can meet these medical standards for nursing home entry. A lack of tight entry screening will allow people access to the waiver who have no intention of entering a nursing home. When this happens, the purpose of the waiver is altered and the result is a cost add-on to Medicaid.

When properly targeted, are waiver services successful in delaying nursing home admission? Our case study evaluation of the California MSSP found that for the waiver population targeted correctly, i.e., for those that would have gone to a nursing home absent the waiver services, the MSSP services were not at all effective in preventing nursing home entry. Our case study in Georgia found similar results.

Our case study of California's developmental services waiver and the multipurpose senior services waiver found that waiver eligibility may have had a slightly adverse effect on SSI cash payments and a slightly favorable impact on Medicare spending. No consideration has yet been given to food stamps, Title XX, or Title III social and aging services cost-shifting. Since two-thirds of all DD/CMI waivered individuals entered the program from community settings, and many were already supported by State-funded residential care services, the potential for shifting the financing burden away from State funds to Federally matched Medicaid dollars is great. We are unable, however, to measure the extent to which States have responded to this incentive.

For waivers serving the developmentally disabled, it appears that waivers which target: (1) severely and profoundly retarded clients; (2) clients who

have been previously institutionalized in ICF-MRs; and (3) adults, rather than children, have the best chance of being cost- effective. In particular, States which limited waiver entry to clients institutionalized in ICF-MRs showed more positive impacts on aggregate ICF-MR use and costs than States which served clients who were already living in community settings prior to waiver admission.

Waivers with the following attributes appear to have the greatest chance of success in terms of delaying or avoiding unnecessary institutionalization: (1) use mandatory pre-admission procedures like those used by the Commonwealth of Virginia; (2) use strong case management models similar to that used by the State of South Carolina; (3) hold waiver administrative costs to a minimum; (4) conduct six-month in-home client assessments using review staff independent of case managers or providers; (5) ensure maximum reliance on privately available support services; and (6) provide a service mix appropriate to delaying nursing home admission.

There are several critical limitations to the 2176 waiver analysis. First, we have conducted only four case studies of waiver programs; other programs may be able to show greater cost-effectiveness. Second, most waivers have only been in effect only three or four years from the time of the analysis. The real effect of the waivers on State long-term care delivery and financing may take more time. Finally, the lack of cost savings does not necessarily mean that the Section 2176 waiver program is bad Federal policy. Although the waiver programs examined do not meet the budget neutrality criterion, and the waiver services may be valuable in themselves, to the recipients, their families, and to society as a whole.

IX. INCENTIVES FOR FAMILY CARE

In formulating policies for financing long-term care services for the nation's elderly, one of the most fundamental issues is the relative contribution of government and family in meeting the demand for care. On the government side, Medicaid is the primary public source of financing for long term care, and the vast majority of these public resources is spent on institutional long term care. In FY 1985, Federal/State expenditures for 1.2 million aged Medicaid recipients in nursing homes totalled $10.4 billion. Another $750 million was spent to provide aged Medicaid beneficiaries with noninstitutional long-term care services such as in-home nursing care, personal care, and home and community-based services provided under the Section 2176 waiver authority.

But most elderly persons with long-term care needs do not receive services from public programs. Approximately three out of four elderly persons who need assistance with activities of daily living such as bathing, dressing, eating toileting, and walking live outside of nursing homes in noninstitutional settings. And of the functionally impaired elderly persons living in the community, only about 15 percent receive assistance from public programs. Long-term care research has consistently documented that informal care providers—family, friends, and neighbors—are the primary source of assistance for elderly persons with long-term care needs.

In addressing long-term care policy issues in the coming decades, policy-makers, legislators, program administrators, and providers will constantly be

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This chapter summarizes findings presented in Brian Burwell, "Shared Obligations: Public Policy Influences on Family Care for the Elderly," MPE Working Paper 2.1.

making judgments about the proper balance between government and family contributions. From the highest levels of policymaking down to individual case managers assessing a new program applicant, judgments are continually being made regarding how the level of public assistance should relate to the ability and willingness of family members and other informal caregivers to also provide care.

This chapter addresses the issue of how public resources and resources within the families of elderly persons with long-term care needs might complement each other more effectively.

Data Sources and Methods

A variety of data sources and data collection methods was used. For an analysis of the effects of Medicaid eligibility policies on family caregiving, Federal regulations governing SSI and Medicaid program eligibility were a primary data source, supplemented by committee staff reports documenting Congressional intent in enacting SSI and Medicaid program reforms, and by other research on Medicaid eligibility policy. Phone and mail surveys were conducted of Section 209(b) States and States which retroactively recoup payments from spouses and parents of institutionalized children to obtain data on State-specific policies.

For the study of States that allow family members to be paid providers of long-term care services, States with such policies were identified through a variety of sources, particularly other States. Contacts were made with key personnel who were knowledgeable about State policy in this area, phone interviews were conducted, and requests were made for documents that described each State's program. In most cases, several interviews were conducted with each State as materials were received and reviewed.

The study of Federal and State tax incentives used documents produced by the Internal Revenue Service, background materials from the U.S. Congress on proposed legislative reforms of tax credits for informal caregivers, and material provided by the Center for Health and Social Services Research in Pasadena, California on State tax incentive programs.

For the case study of Idaho's Relative Responsibility program, primary data were collected through a site visit to the State of Idaho, personal and phone interviews with a variety of persons who participated in the enactment and implementation of the program, and requests for program-related data made to the Idaho Department of Health and Welfare.

How Do Medicaid Policies Affect Family Caregiving?

It is often claimed that Medicaid eligibility, income and coverage policies discourage family caregiving. Under convoluted eligibility rules, it is more difficult for elderly persons to qualify for Medicaid benefits if they live with family members than if they live alone. In addition, there is little incentive for family members to contribute financial support to their elderly parents who are on Medicaid, since public benefits are reduced dollar for dollar for any financial contributions which family members make. In States without medically needy programs, some elderly persons can qualify for Medicaid only if they are placed in a nursing home. Finally, Medicaid service coverage policies have been traditionally biased toward the provision of institutional, rather than noninstitutional, long-term care services. Thus, even for those persons who qualify for Medicaid outside of nursing homes, noninstitutional long-term care services have generally not been covered by most State Medicaid programs.

Since 1980, a number of legislative changes have sought to reverse these incentives for institutional care. For example, under the Medicaid Home and Community-Based Care Waiver program, State Medicaid agencies now have expanded options for providing noninstitutional long-term care services to elderly beneficiaries, and for extending Medicaid eligibility to persons who would otherwise be eligible only if placed in a nursing home. While recent policies are providing greater support to family caregivers, there is also a recognition that public resources should be used to supplement, not supplant, services provided by informal caregivers.

At the same time, State Medicaid agencies now have increased options for using the equity value in an elderly person's home to offset the costs of nursing home care paid by Medicaid, although few States presently take advantage of all the available options. In most cases, elderly nursing home recipients can qualify for Medicaid yet retain the equity value in their homes and pass on this equity to their children without penalty, prior to or subsequent to death. However, if States aggressively pursue options to use home equity resources as a means to offset rising expenditures for nursing home care, some argue that it may influence informal caregiving. That is, some believe that informal caregiving is at least in part motivated by expectations of future inheritance, and removing the prospects of inheriting the family home may alter family caregiving behaviors; if States make clear their intentions to use all of a Medicaid recipient's available assets to reduce Medicaid expenditures, families may increase efforts to keep their elderly kin out of nursing homes and off Medicaid. At the same time, some argue that children may provide less care if they expect the State to lay claim to their parent's entire estate.

How Do States Pay Family Members as Medicaid Providers?

At least thirteen States permit payment of family members as long-term care providers. Most States do not use Medicaid funds to pay family members, although a few do under special circumstances. In defining the scope of these programs, each State has had to develop criteria which specify the conditions under which family members are eligible for public payment. The criteria applied include:

- Excluding family members who are legally responsible for the recipients care, i.e., spouses and parents of minor children;
- Requiring that family members share the same household as the recipient to be an eligible provider;
- Requiring that paid family providers demonstrate financial hardship related to their caregiving efforts;
- Requiring that family providers take in a non-relative recipient to their household in addition to their elderly parent;
- Approving family members as providers only when agency-provided services are not available, e.g., in remote geographical areas; and
- Requiring central approval at the State level of paid family providers as a utilization control mechanism.

In a few States (e.g., California and Wisconsin), payment of family members as long-term care providers emanates from a fundamental program philosophy that eligible recipients should be allowed to select their own providers of care, including family members. In both States, counties once exercised considerable autonomy in implementing this philosophy. Wide variability in payment practices across counties eventually required the establishment of more uniform criteria for paying family members in both

States. Without specific criteria on when family members are eligible as paid providers, and how much they can be paid, programs experienced wide variation in payment practices at the local level. By 1983, California paid about 29,000 relative caregivers more than $90 million annually in its In-Home Supportive Services program, funded by the Social Services Block Grant.

Michigan is one State which uses Medicaid funds extensively to pay family members as long-term care providers. Under the personal care service option, Michigan pays relative caregivers—other than spouses and parents of minor children--as individual contractors, under the supervision of a nurse.

To What Extent Are Tax Incentives Used to Encourage Informal Caregiving, and What Options Exist for Expansion?

Another set of policy options to encourage informal caregiving consists of financial incentives administered through Federal and State income tax systems. Recent legislative initiatives have proposed expanding eligibility and benefits under the Child and Dependent Care Tax Credit. Until 1982, Federal tax credits were limited to day care expenses for children under 15 years of age. Under the Economic Recovery Tax Act of 1981, the credit was expanded to include expenses for out-of-home noninstitutional care for a disabled spouse or elderly dependent. Up to $2,400 in day care expenses purchased for elderly dependents may be claimed under this tax credit. The tax credit ranges from 20 to 30 percent of eligible expenses, depending upon household income. However, eligibility for the credit is restrictive—only taxpayers who share a household with an elderly dependent may claim the credit, and only if all taxpayers in the household are gainfully employed. Thus, if a married couple shares a household with an elderly dependent, but only one spouse works, they are not currently eligible.

Consequently, most legislative proposals to expand Federal tax incentives have included eliminating the "work-related" requirement of the Dependent Care Credit, as well as increasing the value of the subsidy. Other proposed modifications include dropping the requirement that the taxpayer and the elderly dependent share the same household, and eliminating the dependency test, which requires that the taxpayer furnish over half of the elderly relative's financial support.

The major drawback of using the Federal income tax system as a financing mechanism to support informal caregiving is the difficulty of targeting resources efficiently. Public resources for long-term care need to be targeted to the most frail and impaired elderly, and the income tax system is, by nature, better suited to more broad-sweeping policy initiatives. There is no administratively simple mechanism within the existing tax code to establish eligibility for tax subsidies on the basis of chronic disability. A few proposals have attempted to address the targeting issue by adding a disability requirement (determined by the Social Security Administration), limiting eligibility to elderly dependents over the age of 75, or limiting eligibility to specific diagnoses, such as Alzheimer's disease.

To What Extent Are States Implementing Relative Responsibility Programs?

Another policy option to encourage family caregiving (or, more specifically, to discourage institutional placements) is to make adult children financially liable for part of the cost of their parents' care in a nursing home, if their parents are receiving medical assistance through Medicaid. When the Medicaid program was enacted in 1965, States were prohibited by Federal law from counting the income of children as potentially

available to parents in determining Medicaid eligibility. However, as States have felt continuing fiscal pressures from rising Medicaid costs for nursing home care, some have become interested in adopting policies to require adult children of nursing home recipients to share these costs. In 1983, HCFA clarified that States may do so under a State law of general applicability, meaning that the law must apply to all adult children, not just the adult children of Medicaid recipients.

In January of 1983, the Idaho legislature enacted a relative responsibility law requiring responsible relatives--spouses, parents, and adult children--of nursing home recipients receiving Medicaid to contribute to the cost of their care. The law had been fiercely debated and narrowly approved. Two primary reasons for its passage were: (1) the State was facing a severe fiscal crisis related to the 1981-1982 recession; and (2) other strategies to contain Medicaid long-term care expenditures had proven unsuccessful.

Implemented in October of 1983, the Idaho Relative Responsibility program identified responsible relatives of nursing home recipients on Medicaid, requested income information from these relatives, and determined a monthly assessment based upon the relatives' adjusted income. The maximum assessment amount was $250 per month, or 25 percent of the monthly Medicaid payment amount, whichever was less. The average assessment was $40 per month, and one-third of all responsible relatives were exempted from making any contribution at all, since their incomes fell below the established threshold. Idaho was considerably more successful in collecting contributions from in-State relatives than out-of-State relatives, who comprised almost half of all responsible relatives identified.

In March of 1984, six months after the program was implemented, the State Attorney General rendered an opinion that Idaho's Relative Responsibility law was not a law of general applicability, and therefore out of conformance with Federal requirements. The basis of the opinion was that the law applied only to children of elderly persons receiving Medicaid assistance in nursing homes, not to the children of all elderly persons receiving public assistance. Proponents of the program claimed that the opinion was politically motivated, and that the law could have passed a test of general applicability if challenged in the courts. Nonetheless, upon receiving the Attorney General's opinion, the State terminated the program and returned all collected payments to relatives who had contributed.

It is apparent that while some other States are interested in adopting similar family responsibility programs, they are reluctant to do so unless the legal criteria for a "law of general applicability" are more specifically defined. If States cannot enact laws which are specific to children of elderly nursing home recipients on Medicaid, they are unlikely to pass such laws. The only other option is to revise Medicaid statutes to allow States to recover payments made for elderly nursing home recipients from their adult children retroactively. Laws of general applicability are not required for States to retroactively recover Medicaid costs for institutional care from spouses and parents of Medicaid beneficiaries, however, and a number of States do so.

Summary

Policymakers in the arena of long term care recognize the need to achieve a fair balance between public assistance and family caregiving in meeting the demand for long term care services. Recent policy initiatives include paying

family members with public dollars for providing long term care assistance to their elderly kin; modifying Federal and State tax policies to provide financial incentives for enhanced family caregiving; and implementing programs which would require children whose parents are in nursing homes and receiving medical assistance to pay a share of the nursing home cost.

Although recent State and Federal experience with these policy initiatives provide some basis in experience for further legislation and experimentation, the scope of these initiatives is still quite limited. Effective approaches for achieving a more proper balance between the shared obligations of government and family are not easy to discern. There is little empirical information on the real consequences of these various policy initiatives. As the demand for long term care grows dramatically over the next fifty years, the relative role of government and family as providers of long term care services will also grow as a health care policy issue.

X. HOW HAS MEDICAID CHANGED?

The intent of the 1981 OBRA and more recent legislation, generally speaking, was to achieve Medicaid cost control by adjusting Federal policies that affect expenditures directly (e.g., AFDC eligibility policy) and at the same time providing States with new management tools to foster cost containment as they chose. Has this intent been realized? If so, what have been the consequences (if any) for access to and delivery of care? Has the program fundamentally changed? What about the future?

The Original Intent and the Perceived Need for Change

It is useful in considering the effects of recent changes to Medicaid to remember that the framers of the original 1965 Social Security Amendments--and the subsequent legislation passed by the 50 States--had in mind an entitlement program for those who could not pay for their own medical needs. The California enabling legislation contains a fair statement of the fundamental intent:

> The means employed shall be such as to allow, to the extent practicable, eligible persons to secure health care in the same manner as the public generally.

Essentially, this meant that the low-income groups should be able to use the same medical care system as available to the population generally.

Not surprisingly, at least in retrospect, Medicaid costs skyrocketed as the program encountered the perverse incentives we now recognize as characterizing the fee-for-service and cost pass-through health care system that prevailed during the early years of Medicaid.

States were aware of the drastic increases in costs in the health care sector, and made efforts throughout the 1970s to control unit costs and to

take control of State spending on health care (as on other services). In some cases, this led to shifting costs from 100 percent State-funded programs to the Federally matched Medicaid program. In the later years of the decade Medicaid spending was growing by over 16 percent annually, nearly 5.5 percent annually in inflation-adjusted terms.

This growth concerned not only the States--which felt that if they had greater freedom in program design they would have more effective control over costs--but also the Federal government--which felt the need to curtail the Federal contribution to Medicaid spending as part of a general budget-cutting move. The combination of the two led to the passage of 1981 OBRA, initiating the most substantial changes in Medicaid history:

- Reductions in Federal financial participation--the Federal match on State Medicaid spending;
- Tightening of eligibility for AFDC cash benefits, to which Medicaid eligibility was tied;
- Greater flexibility in States' choice of Medicaid policies than the statute previously allowed--including ability to change payment systems for hospitals, waivers to allow innovation in funding of home- and community-based care for the frail elderly and disabled and mentally ill, the power to curtail recipient freedom of choice by initiating primary care management programs, and patient cost sharing.

Post-OBRA legislation also made important changes--in particular, providing flexibility for the States to increasingly separate Medicaid coverage from eligibility for Federal income assistance programs.

Did OBRA Curtail Medicaid Expenditure Growth?

There is no doubt that the trend in Medicaid spending changed abruptly after 1981. Actual spending growth per year fell from 16 percent a year to just over 7.5 percent, and inflation-adjusted spending dropped from an annual

rate of increase of over 5 percent to zero growth for the 1981-1984 period. Much of the reduction occurred in the first year; but even so, spending growth rates have remained below their pre-OBRA levels.

How much of this was due to OBRA, and how much to the major economic recession of the early 1980s? Both factors were at work. Evidence indicates that both the reduction in the Federal matching rate and changes in the Medicaid programs themselves contributed to the reductions in expenditure growth. In addition, the recession's effect on State budgets also had a cost-restraining effect. Interestingly, the recession-induced increases in unemployment, which should have increased the pool of Medicaid eligibles, did not have a counteracting effect--suggesting that there is always unmet demand in the Medicaid program and that the recession simply added to the eligible group who failed to receive care.

These effects are consistent with evidence on the long-run determinants of State Medicaid expenditures. Richer States spend more than poorer States, other things equal, on their Medicaid programs. However, States with higher matching rates (i.e., the poorer States) spend more than they would if the rates did not vary inversely with State income levels. But although matching rate differences serve to reduce inter-State differences in Medicaid spending (and, thus, have an equity-enhancing effect), this effect is not strong enough to offset entirely the inequities caused by State income differences.

A final fact about inter-State differences is also important. When all differences due to State income, Federal matching rates, and a variety of demographic and environmental characteristics are taken into account, there still remain substantial differences in the generosity of the Medicaid program across regions. Political philosophy and public attitudes toward Medicaid

recipients are clearly important influences irrespective of States' living standards or the socioeconomic characteristics of their populations.

Did the New Management Tools Provided by OBRA and Other Legislative Changes Contribute to the Slowing of Expenditure Growth?

As noted in the previous section, the evidence indicates that both financial incentives and changes in the program itself had cost-restraining effects. It is useful to ask which of the tools the States had at their disposal were effective in this respect and which were not. Let us recall what those tools were:

- Tools in place before OBRA: Control over physician fees, nursing home reimbursement, reduction in benefit coverage, control over income standards, and coverage of optional groups.
- New tools: Expanded control over hospital reimbursement, new flexibility through home- and community-based care waivers, power to curtail recipient freedom of choice and initiate primary care case management, and changed patient cost-sharing rules.

Of the new tools, control over hospital reimbursement was a major contributor to slowed expenditure growth. Compared to where they were in 1981, 30 States had significantly changed their Medicaid hospital reimbursement programs by 1985 to some type of prospective payment system. All States, even those retaining traditional payment methods, had reductions in the rate of growth of hospital reimbursement; but States that introduced prospective hospital rate-setting schemes after OBRA had more substantial reductions in growth. States with rate-setting schemes that applied only to the Medicaid program achieved their total effect in the first full year of implementation. States with schemes that included all payers, however, achieved reductions in

hospital spending growth that continued at least through 1984 (the end of the observation period).

Selective contracting and DRG-based systems were the two most innovative changes implemented. Case study evidence indicates that both can be implemented and operated in the Medicaid context. No conclusive evidence is yet available to indicate which of the two is more effective as a long-run container of Medicaid costs.

Community-based waivers to permit States to broaden Medicaid coverage of long-term care services as an alternative to institutionalization have been used extensively by the States. By the end of FY 1985, 75 waiver programs were operating in 42 States, and applications for new waivers and renewals were also continuing at a rapid rate. Available evidence indicates, however, that the programs adopted under the waivers may not be contributing to aggregate Medicaid savings, at least in the four waiver programs that were intensively studied as part of this project. Waivers both for the frail elderly and for the mentally retarded increased Federal Medicaid costs, although they may have reduced aggregate State costs through the refinancing of State-funded programs. These results are consistent with the results from the National Channeling Demonstration, a random assignment experiment designed to test the cost-saving potential of community-based care. In waivers for the frail elderly, the evidence indicates that States were not able to target persons at high risk of institutionalization--in spite of expectations--although the individuals served were in need as measured by their degree of functional impairment and lack of informal support. In waivers for the mentally retarded, refinancing is the key issue--whether or not the waiver is

being used to finance community-based services that, absent the waiver, would have been financed entirely with State funds.

Loosening recipient freedom of choice restrictions and permitting establishment of primary care case management programs (PCCM), stimulated considerable State innovation too. Over the past five years more than half the States have made the decision to implement PCCMs. They were typically optimistic about the potential of the PCCM to save money and also to improve access to and quality of service.

It is too early to say with confidence what the outcome of the PCCM finance and delivery model will be. States encountered substantially more difficulty than they had anticipated in the implementation stage, so there is not yet much experience on which to base an evaluation. Some of the difficulties are probably endemic and can be expected to limit the cost-saving potential of PCCMs. For example, Medicaid already pays physicians at relatively low rates. This makes it hard to find physicians who will undertake the primary care case management role at a rate which does not drive up costs. The financial risk is exacerbated for capitation schemes by the facts (1) that the Medicaid population has a high turnover--making it difficult even conceptually to estimate an appropriate capitation rate, and (2) that at least segments of the Medicaid population are at more than average risk for high health care costs--particularly once they get into the service system on a regular basis--making predicting average per capita costs particularly hazardous. The evidence from States so far indicates that PCCMs may be contributing in a very minor way to Medicaid cost savings, although not as much as estimates made by the States themselves might suggest. It is

clear, however, that the States are generally very positive about the potential of the PCCMs and are committed to their expansion.

Cost sharing is not, strictly speaking, a new tool. Use of cost sharing has been a State option since Medicaid began in 1965, and by the end of the 1970s, 35 States had tried cost sharing, almost always through recipient copayments. The TEFRA 1982 legislation, however, increased and made more complex the range of services and recipients who could be subject to cost sharing. Unexpectedly, one of TEFRA's effects was to prompt some States to drop their cost-sharing programs, citing the administrative complexity introduced by TEFRA as the reason. Only 26 States currently cost share. Evidence indicates that the Medicaid savings from cost sharing in the short term may be positive though very minor. Little evidence exists about longer-term effects, though the concern exists that cost sharing may inhibit use of preventive services, thus potentially increasing use of (and expenditures on) acute care.

Thus, of the new tools introduced since 1980, only prospective hospital rate-setting systems have resulted in substantial savings. But the new financial incentives, combined with States' own needs to cut costs, have led States to continue their effective efforts to restrain physician fees, and to cut expenditures through such means as prior authorization, generic prescriptions, payment limits by diagnosis, and restricting eligibility and range of service--as is discussed immediately below.

What Have Been the Effects on Access and Delivery of Care?

One objective of the 1981 OBRA changes to Medicaid eligibility was to reduce coverage of the working poor; this objective was clearly met. The objective of more recent years has been to provide the States with the

flexibility to gain Federal financial participation for some persons in poverty who are not on welfare cash assistance but who nonetheless lack adequate health coverage. In fact, access has improved somewhat for some pregnant women and younger children—particularly so-called Ribicoff children (children in low-income two-parent families). However, since by far the majority of recipients are eligible for Medicaid through the AFDC and SSI cash programs, these recent eligibility changes were a relatively minor influence on access during the 1980s. Much more important was the inflation-adjusted decline in AFDC benefit levels, over which States retain wide discretion and which led to reduced access for AFDC-related recipients over the 1980s. In contrast to AFDC benefit levels, Federal SSI benefits have more than kept up with inflation, with the result that Medicaid's coverage of the elderly poor and disabled has not eroded.

These opposing trends, combined with State efforts to meet the need for long-term care through noninstitutional and institutional means, have led to Medicaid becoming more a program for the frail elderly and disabled and less a program for poor families and children. In 1985, the SSI-related groups accounted for only 29 percent of all Medicaid recipients, but for 74 percent of expenditures.

The effects of cash assistance payment levels on these trends in eligibility have been exacerbated by the increases in poverty over the period, with children and young adults most affected. According to CPS data, the proportion of children on Medicaid increased by less than 4 percent between 1979 and 1983, for example, while the proportion of children in poverty increased by almost 35 percent. The Medicaid coverage of young adults (18-40) remains practically steady, whereas the percent of young adults in poverty

increased by over 60 percent. In contrast, the proportion of elderly in poverty declined over the period, and Medicaid's coverage of the elderly poor remained stable.

Who were the people who lost eligibility over the period who would have been eligible under previous criteria? They were predominantly, as the legislative initiatives intended, the working poor and near poor. Estimates indicate that about half of them acquired other insurance, but about half remain without insurance--presumably contributing to the uncompensated care problem. It should also be noted that the Federal changes in eligibility did not reduce inequities in coverage across States, in large part because the AFDC payment standards, particularly in the poorer States, are so low.

What about changes in service delivery patterns for those who are Medicaid eligible? Evidence on this is not completely in, but several things are already relatively clear. The scope of services is broader for long-term noninstitutional care and probably somewhat curtailed for acute care. Consistent with this, spending on acute care was curtailed more sharply than spending on long-term care. For the nonaged, nondisabled caseload, in other words, the service package may have become more narrowly focused on basic, nonoptional services. Hospital care may have improved, given that less of the caseload is being treated at for-profit and nonteaching hospitals--leaving more Medicaid eligibles going to the teaching hospitals. However, doctors' services may have declined. Certainly choice has narrowed, given that fewer doctors participate. It is also possible that those who do take Medicaid patients, given the successful physician fee controls imposed by the States, may provide less service than is received by the general population--and less than they provided in the pre-OBRA environment. On the positive side, the

movement towards case managed care may increase the continuity of care, and the receipt of regular more preventive types of care.

There is only partial evidence on the issue of quality of care. This project has encountered no major warning flags on quality. And it should be noted not only that Medicaid quality control mechanisms were not reduced by OBRA and subsequent legislation, but also that most home- and community-based waiver programs have stricter quality scrutiny and monitoring requirements than the Medicaid program generally. The PCCM initiative is subject to the regular peer review and complaint processing mechanisms. Initial implementation indicated some breakdown in patient-doctor relationships; but these were rapidly taken care of, and there are indications that the trend is toward greater continuity of care and, therefore, possibly firmer long-term patient-doctor relationships.

A Summing Up and a Look at the Future

The 1980s have witnessed major successes in controlling Medicaid expenditures, particularly compared with the record of other payers. This success can be traced to some restrictions on eligibility, and some reductions in expenditure per recipient. The major management tools to which this cost control is attributable are hospital rate-setting systems, restrictions on nursing home bed supply, and a trend toward service restrictions to a basic benefit package. Other research evidence also indicates that physician fee freezes have restricted the number of Medicaid patients served. Medicaid has, thus, become much more of a targeted program than the entitlement conception envisioned in the initial legislation.

Reductions in eligibility have affected families and children, rather than the elderly and disabled. In the context of increased poverty in the

1980s, families and children near the poverty line have experienced major cutbacks in access. Reflecting the intent of OBRA 1981, these are predominantly the working poor. It should be noted, however, that program expenditures were not reduced as much as the enrollment cutbacks might suggest, because those dropped from the rolls were the relatively healthy low-use portion of the caseload. It should also be noted that pregnant women and younger children not on cash assistance have somewhat greater potential access than before as a result of more recent legislation.

Until 1986, the link between Medicaid eligibility and AFDC payment levels prevented the States from making major moves to expand eligibility to noncash groups. For the first time, 1986 OBRA allows States to separate Medicaid eligibility completely from the AFDC or medically needy financial criteria. It will be important to see whether this change in fact stimulates major new coverage initiatives by the States.

The home- and community-based waivers and cost-sharing features of the new legislation may not have proven cost effective from the Federal perspective. This may in part be because they have been accompanied by regulations that make Medicaid less rather than more manageable from the States' point of view. But it is also probably due in part to the inevitable fact that the States have somewhat different objectives from those of the Federal government. Both, obviously, are interested in cost containment in the sense of getting the most possible from scarce resources. But the States are also interested in using to the maximum degree possible Federally matched rather than 100 percent State dollars.

The evidence accumulated in this Medicaid evaluation project highlights several important issues for the future:

- What will the States do with respect to capitation? They have made only modest moves so far, but express a need for both capitated and more traditional alternatives. The potential for cost saving in many States, particularly large ones, seems slim, however. Medicaid physician fee rates are already low enough to inhibit physician participation. In addition, the high turnover of the Medicaid population combined with the difficulty of predicting health care needs for parts of that population increase the risk inherent in setting a capitation rate.

- What will happen to nursing home expenditures? They have grown less than other areas of Medicaid spending in the 1980s. However, the frail elderly population is growing, hospitals are discharging sicker patients, and there are stringent controls on nursing home bed supply in most States. All these factors suggest that unmet demand may be growing. Nursing homes may be selecting the less expensive applicants. If bed supply increases, costs are almost certain to rise.

- What utilization and cost controls will be placed on the coverage of home and community-based services, particularly given the lack of evidence that coverage of these services reduces nursing home expenditures?

- Even though acute care expenditures are a declining proportion of total Medicaid spending, for the elderly Medicaid acute care expenditures are rising more rapidly than long-term care expenditures. This raises the question of the extent to which Medicaid is

becoming the catastrophic illness protection for the Medicare-eligible poor.

- What will happen to hospital costs? The answer depends importantly on how hospitals are reimbursed for non-Medicaid patients. If cost-sharing innovations in rate setting are adopted by all payers, the Medicaid program will benefit. But evidence suggests that Medicaid can reap only short-run savings if other third-party payers do not adopt prospective rate-setting schemes.

- State Medicaid programs have become more, rather than less, diverse since 1980--raising the issue of increasing inequities in access to care across States. Recent (1986) legislation begins to untie Medicaid eligibility from cash assistance and medically needy payment standards, and permits Medicaid coverage of families and individuals up to the poverty line. It remains to be seen how the States choose to handle these new options, but it seems likely that State diversity may be increased rather than reduced.

- Upward pressure on costs seems inevitable from the spread of AIDS and the likelihood that victims will exhaust their resources on the relatively intensive service needs that accompany the later stages of that disease.

- Methods of care are becoming increasingly sophisticated in a technological sense. This will put upward pressure on costs of the health care system as a whole--implying upward pressure on Medicaid costs to the degree that we, as a society, are unwilling to relegate

APPENDIX A

Medicaid Program Evaluation

Working Papers*

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* Copies of MPE Working Papers listed in this appendix may be obtained by contacting:

Dr. Harry Savitt
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our poorer members to drastically lower levels of care than the rest of society receives.

- As Medicaid increasingly becomes a targeted benefit program and less of an entitlement, the States will have to make choices about where to target their limited resources across the various groups of potential Medicaid eligibles. In particular, will the growing demand for long-term care services consume an ever-increasing proportion of Medicaid dollars?

Whatever problems the future may bring, the evidence produced by the Medicaid Program Evaluation indicates that States are using the increased flexibility provided by recent legislative initiatives to manage their Medicaid programs and to control costs. The new flexibility has been accompanied by increased administrative complexities, however, and States are still in the process of adjusting to them. The full effect of the changes may not become apparent for several more years.

Medicaid Program Evaluation
Working Papers

Working Papers		Author(s)
I. Home and Community-Based Care		
MPE 1.1	Report to Congress: Studies Evaluating Medicaid Home and Community Based-Care Waivers	Steinhardt, Clinkscale, et al.
MPE 1.2	Evaluation of Medicaid Section 2176 Home and Community-Based Care Waivers: Interim Report	Steinhardt
MPE 1.3	Evaluation of the California Developmentally Disabled Services (DDS) Waiver	Burwell
MPE 1.4	A Profile of Medicaid Home and Community-Based Care Waivers, 1985: Findings of a National Survey	Laudicina and Burwell
MPE 1.5	An Empirical Evaluation of the California Multipurpose Senior Services Project	Vertrees and Manton
MPE 1.6	An Evaluation of the California In-Home Medical Care Program	Clinkscale and Pollatsek
MPE 1.7	Evaluation of the Georgia Alternative Health Services (AHS) Medicaid Waiver Program	Vertrees and Manton
MPE 1.9	Waiver Impacts on Medicaid Nursing Home Use and Expenditures	Vertrees and Manton
MPE 1.10	Evaluation of Medicaid Section 2176 Home and Community-Based Care Waivers	Clinkscale
MPE 1.11	Survey, 1986	Clinkscale and Ray
MPE 1.12	Virginia Case Study	Clinkscale and Ray
MPE 1.13	Maryland Case Study	Burwell and Clinkscale
MPE 1.14	Update of 1.9: Aggregated Impact Study	Vertrees and Clinkscale

Working Papers		Author(s)
MPE 1.15	Evaluation of Medicaid 2176 Home and Community-Based Care Waivers - Final Report	Clinkscale
MPE 1.16	The Impact of the Medicaid Home and Community-Based Waiver for the Mentally Retarded in Maine	Coburn

2. Family Responsibility

MPE 2.1	Shared Obligations: Public Policy Influences on Family Care for the Elderly	Burwell

3. Hospital Reimbursement

MPE 3.1	Selective Contracting in California: The First Year	Koetting and Olinger
MPE 3.2	National Impact Study of Alternative Reimbursement Waivers	Cromwell and Hurdle
MPE 3.3	State Medicaid Inpatient Hospital Reimbursement: Summary of State Programs	Korda and Koetting
MPE 3.4	Inpatient Hospital Reimbursement: Medicaid Hospital Reimbursement in New Jersey Under a DRG All-Payer System	Koetting and Korda
MPE 3.5	Refining Prospective Payment in the Eighties: Summary of State Programs	Korda
MPE 3.6	National Impact Study of Alternative Medicaid Reimbursement Waivers: Second Year Report	Cromwell and Hurdle
MPE 3.7	Medicaid Alternative Hospital Reimbursement in Three States: Pennsylvania, Illinois, Texas	Olinger
MPE 3.8	Inpatient Hospital Reimbursement: A Comparison of Approaches to Prospective Payment	Mennmeyer et al.

4. Freedom of Choice

MPE 4.1	A Descriptive Analysis of States' Responses to the Provisions of Section 2175 of P.L. 97-35, The 1981 Omnibus Budget Reconciliation Act	Bartlett et al.

Working Papers		Author(s)
MPE 4.2	Michigan's Physician Primary Sponsor Plan: Implementation Primary Care Case Management in Medicaid, Volume I	Bell and Rosenthal
MPE 4.2b	Michigan's Physician Primary Sponsor Plan: Implementation Primary Care Case Management in Medicaid, Volume II Attachment	Bell and Rosenthal
MPE 4.3	Utah's Choice of Health Care Delivery Program: Implementing Primary Care Case Management in Medicaid	Rosenthal, Beyna, Bell
MPE 4.4	Primary Care Case Management in Medicaid: Case Studies of Four State Programs	
MPE 4.5	Primary Care Case Management in Medicaid: Findings from Six Case Studies	Bell et al.
MPE 4.6	An Evaluation of Utah's Primary Care Case Management Program for Medicaid Recipients	Long and Settle
MPE 4.7	The Impact of the Physician Primary Sponsor Plan on the Medicaid Program in Michigan	Kosinski
MPE 4.8	Report to Congress: Medicaid HMO Disenrollment	Adler
5. Eligibility		
MPE 5.1	Medicaid Eligibility After the Omnibus Budget Reconciliation Act of 1981	Cohen and Holahan
MPE 5.2	Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA, and DEFRA Provisions, and State Responses	Hill
MPE 5.3	The Impact of Eligibility Changes Under the Omnibus Budget Reconciliation Act of 1981 on the Characteristics of the Medicaid Program	Long and Settle
MPE 5.4	Cutbacks in Medicaid Eligibility Under the OBRA of 1981: Implications for Access to Health Care Among the Newly Ineligible	Long and Settle
MPE 5.5	Changes in the Characteristics of the Non-Institutionalized Medicaid Population	Swartz
MPE 5.6	Medicaid Eligibility: Analysis of Recent Trends and Special Populations	Burwell and Rymer

Working Papers		Author(s)
MPE 5.7	The Impact of Variations of AFDC and Medicaid Eligibility on Prenatal Care Utilization	McDonald and Coburn
6. Cost Sharing		
MPE 6.1	A Review of Cost-Sharing in Medicaid	Beck
7. Federal Financial Participation		
MPE 7.1	Success and Failure in Containing Medicaid Costs: Twelve States' Experience Between 1981 and 1982	Cohen
MPE 7.2	State Budget Priorities and Medicaid	Davis and Gullo
MPE 7.3	The Effects of the 1981 Omnibus Budget Reconciliation Act on Medicaid	Holahan
MPE 7.4	The Effects of Reimbursement and Utilization Control Policies	Zuckerman
MPE 7.5	Federal Matching Rate Reductions, the Recession, and Medicaid Spending	Cohen
MPE 7.6	An Overview of Medicaid Acute and Long-Term Care Expenditures, 1978-1984	Holahan
MPE 7.7	Medicaid Policy and the Substitution of Outpatient for Physician Care	Cohen
MPE 7.8	Comparative Survey of Medicaid Reimbursement Systems for Long-Term Care Services, 1980-85	Laudicina
8. Other Issues		
MPE 8.1	Explaining the Effects of Medicare PPS on Medicaid	Trutko et al.
MPE 8.2	Children and Medicaid: The Experience in Four States	Rymer and Adler

Working Papers		Author(s)
9. Synthesis		
MPE 9.1	Medicaid Program Evaluation: A Synthesis of Interim Findings	Holahan and Feder
MPE 9.2	Medicaid Program Evaluation: Summary Report	
10. Planning Studies for MPE		
MPE 10.1	Evaluation Options for Medicaid	Rymer
MPE 10.2	Evaluation Options for Medicaid: Technical Appendix	Rymer
MPE 10.3	Short-Term Evaluation of Medicaid	Rymer and Burwell

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